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Reader's Guide

Urological diagnosis and treatment have reached a degree of exactness and precision which demands a high level of skill on the part of the nurse who is assigned to this branch of the service. It is true that a great many of the details of care will be performed by the surgeon himself, an interne, or an orderly. Nevertheless, there are many factors in the care of both pre- and post-operative urological cases which are the direct responsibility of the nurse. **Dr. Charles A. Cawker,** who is urologist at Shaughnessy Hospital, Vancouver, has outlined these nursing responsibilities clearly and fully. Supplementing Dr. Cawker's advice, we present specific details of the nursing care which is applicable to the various types of operative treatment for prostatism. **Evelyn Myers** is the supervisor of the urological department at the Victoria General Hospital, Halifax.

Those of you who read **Dr. B. D. B. Layton's** analysis of present-day treatment methods for syphilis in the March, 1947, issue, will be greatly interested in his companion article on the treatment of gonorrhea which is presented here. The appalling increase in the number of cases of this disease has caused deep concern. However, the use of the antibiotics promises a more swift and complete cure. Dr. Layton is chief of the Division of Venereal Disease Control in the Department of National Health and Welfare.

Last month we had planned to bring you this excellent interpretation of the **Canadian Citizenship Act.** Somehow our space was all filled up so this material had to be hoisted to this issue. Reading this material in conjunction with the above-mentioned article, perhaps it will dawn on us that, though we may swell with pride at the realization that we may call ourselves Canadians before the whole world, citizenship implies certain obligations which many women are prone to shirk.

The Committee on Public Health Nursing is combining forces with the French page this month in the analysis of present-day use of B.C.G. to combat tuberculosis. **Georgine Badeaux** is assistant director of the medical-social service of the Bruchési Institute for Tuberculosis in Montreal. A condensation in English is appended for those public health nurses who are unable to read the original article.

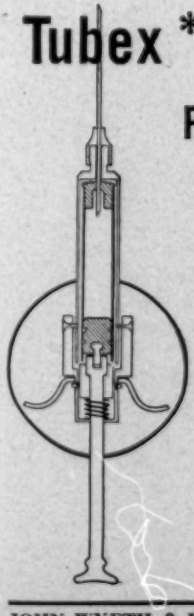
The Committee on Institutional Nursing is devoting most of its special pages this year to the consideration of various aspects of personnel practice. Last month a general discussion of the technique to be used in the introduction of new nurses to hospital staff paved the way for this detailed description of how it is being done in a specific situation. **Margaret M. Street** has occupied the position of ward instructor at the Ross Memorial Pavilion, Royal Victoria Hospital, Montreal, for a year and a half. In that time, a large number of nurses, both students and graduates, have benefitted from her orientation program. Prior to this work, Miss Street was executive secretary of the Manitoba Association of Registered Nurses.

Lyle M. Creelman had the unique opportunity of serving as chief nurse with the UNRRA mission when it was first organized in Germany. Her documentary report on conditions among the civilians of Germany, the Displaced Persons, the problems of reorganizing the health facilities, including hospitals, and the progressive steps taken to provide anything approaching adequate nursing service makes very interesting reading. The first instalment of this report is presented herewith. It will be concluded next month.

There are many medical terms applied to various conditions of the circulation but we cannot find one that suits our particular problem. What would you call "growth of the circulation?" Anyway, here are the figures for the number of copies for June, 1947, issue, by provinces: Alberta, 837; British Columbia, 1,198; Manitoba, 420; New Brunswick, 601; Nova Scotia, 535; Ontario, 3,438; Prince Edward Island, 106; Quebec, 1,060; Saskatchewan, 592.

Christopher Chisholm, our "sun baby" on this month's cover, is the healthy, happy son of Mr. and Mrs. H. C. Chisholm of Westmount, P.Q. Christopher, like all active little boys, would sooner get into mischief than eat. Here he pauses for a jiffy to consider what to do next.

Tubex *



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"It has to be considered whether the damage to tissues, whether gross or only microscopic, will outweigh the advantage possibly gained by killing bacteria; some antiseptics are caustic or irritant, others comparatively bland." *Garrod, L.P., and Keynes, Geoffrey, L. (1937) Brit. Med. J., 2, 1253*

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REFERENCES:
(1) West. J. Surg. Obst. & Gyn., 51:150, 1943;
(2) Clin. Med. & Surg., 46:327, 1939;
(3) Am. J. Obst. & Gyn., 46:259, 1943;
(4) Am. J. Obst. & Gyn., 48:510, 1944.

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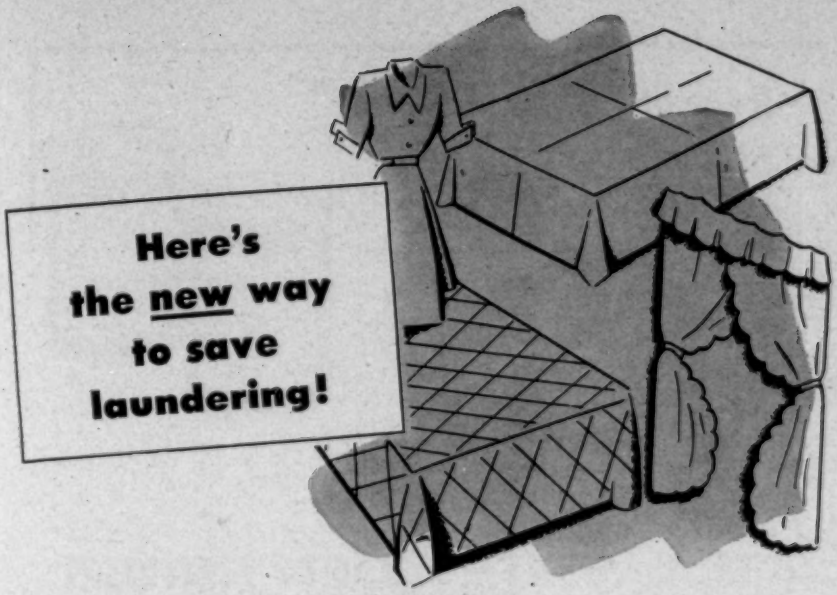

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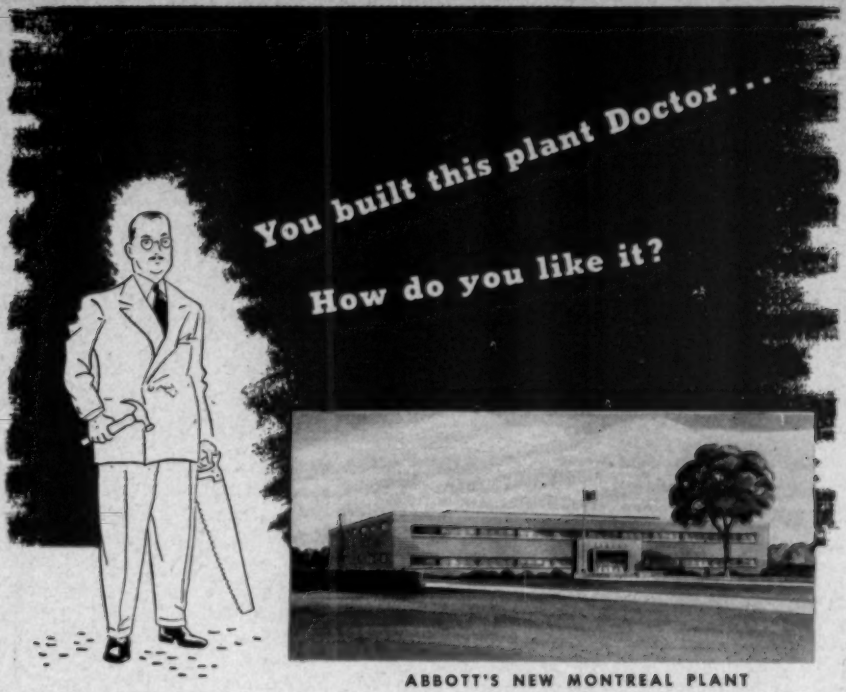

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PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-THREE NUMBER SEVEN

MONTREAL, JULY, 1947

Vacation Thoughts

THOUGH maintaining adequate staffs in hospitals and health organizations necessitates some of the nurses having earlier holidays, the time preferred by most nurses is during July or August. The boon of an annual vacation is one of the most precious perquisites of the personnel policies instituted for busy staffs. In most areas, at least three weeks' vacation is provided. Even better is four weeks. The growing tendency of many staff nurses to resign from their positions in order to have a whole summer off, is, of course, a sign of our times. With the existing demand for nurses all over the country, it is easy to find a new position when the long holiday is over. Unless this extended vacation is necessary from the point of view of overtaxed energy, it is a form of selfishness which should be strenuously discouraged. The probable result is that others, needing a change equally as much, have to forego or curtail their vacations in order to provide even partial coverage of the services.

What are you planning to do for your holidays this month or next? No doubt your plans are well advanced. If you are going to any of the popular resorts, your reservations will have been made months ago. Seashore or mountain, dude ranch or fashionable hostelry, loafing or traveling—by air, rail, ship, bus or car—you are hoping for the best vacation you have had in years. Nevertheless, a word or two about the value of true recreation may help to make the holidays more enjoyable and the return to work less arduous.

Recreation is not limited to a few types of activity. It takes literally hundreds of forms from the most strenuous to those that require nothing more than sitting still and listening—to the surf pounding on the shore, the wind in the treetops, or the buzzing of bees in a clover patch. Vigorous exercise is an invaluable form of exercise in youth and useful when youth is past; but when middle age is reached, moderation in exercise is a form of insurance for more years to enjoy other recreations.

What ever form your recreation

takes, its primary purpose is to relieve mental and nervous strain, to help in recharging the human dynamo that is you, to give you a new zest for your work. In order that this re-creation may occur, it is wise to provide for a lull, a period of relaxing at the beginning of the holiday. At least two or three days of quiet relaxation will give you the necessary vim to launch out on your more exciting and vigorous plans. The same period of resting at the end of your holidays will bring you back on duty untired and well fortified for the next eleven months of work. To go hard during the whole period results in strain which may tear down instead of building up your reserves.

You will get the greatest enjoyment and benefit from your vacation if you post a few "beware" signs where your mind's eye can see them. "Beware of poison ivy!" "Be careful of an overdose of sunshine!" Make up your own list. It should not be necessary to suggest such reminders to nurses but it is a curious commentary on our alleged knowledge and understanding of cause and effect that so many nurses adopt the attitude "it cannot happen to me!" It can and it does happen. Let us all try to make this summer an exception.

The Canadian Nurses' Association is Incorporated

Bill 171, an "Act to incorporate the Canadian Nurses' Association," has now become part of our history.

During the past ten years the question of incorporating the Canadian Nurses' Association has been considered frequently, both at executive and general meetings. In 1938 and 1940 it was decided to ask for incorporation, but in 1941 the matter was tabled. In 1945 the subject was reopened and in 1946 at the biennial meeting, following the adoption of a new Constitution and By-Laws, the following resolution was passed:

That if on November 15, 1946, the majority of the total voting strength of the Canadian Nurses' Association have concurred either by voting or not voting thereon, in the adoption of the new Constitution and By-Laws, the Executive Committee of the Canadian Nurses' Association be instructed to apply for incorporation of the Canadian Nurses' Association by the Parliament of Canada.

Accordingly, when the prescribed

SENATOR N. M. PATERSON

W. M. BENIDICKSON, M.P.

conditions were fulfilled and the new Constitution and By-Laws came into force on the 15th of November, 1946, our legal counsel, Mr. W. B. Scott, K.C., was instructed to apply for incorporation. The Bill was drafted and presented first to the Senate, and introduced by Senator Norman Paterson, of Ottawa, who gave the Bill his unqualified support.

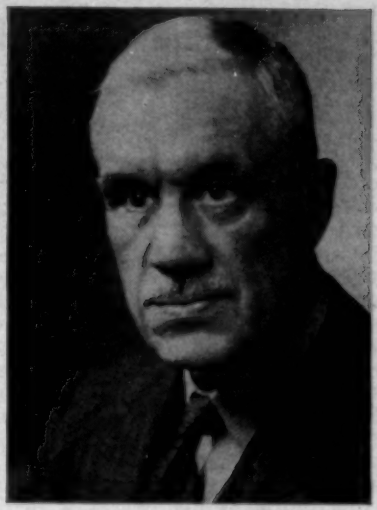
A small delegation, consisting of our first vice-president, Miss Ethel Cryderman, Miss Agnes Macleod, Sister Hermine, of Hull, Miss Gertrude Hall, Mr. W. B. Scott, K.C., and Miss Eileen Flanagan, the convener of the Legislation Committee, was present when the Bill came before the Private Bills Committee of the Senate, and was graciously received.

The Bill was passed by the Senate on the 23rd of April, 1947. Our sponsor for the House of Commons was Mr. W. M. Benidickson, M.P., for Kenora, Ontario, who also gave it and us his attention and full support. It took a great deal of effort, also, on the part of our able counsel, Mr. W. B. Scott, K.C., our national and provincial officers, and many others to satisfy the members of the Private Bills Committee of the House of Commons, that we wanted the Bill in the form in which it had been adopted by our members. With a minor clarifying amendment, it passed the committee on May 21. On May the twenty-third, nineteen hundred and forty-seven, it finally passed the House of Commons after being unanimously adopted on third reading.

As before, a delegation had appeared before the committee, consisting of the president, Miss Rae Chittick, Miss Ethel Cryderman, Rev. Sister Delia Clermont, Miss Agnes Macleod, Miss Nettie Fidler, Miss Gertrude Hall, Mr. W. B. Scott, and Miss Eileen Flanagan, and had been given every attention and courtesy.

Thus the unincorporated association, which has been doing such excellent work during the past thirty-nine years, has now been given legal status. By this Act of Incorporation, the Canadian Nurses' Association benefits by being officially recognized as a profession by the Parliament of Canada. It adds prestige and dignity to the association and, while providing an official way of co-ordinating the activities of the nine provincial associations who form its membership, it in no way interferes with the rights of the provincial associations, each of which is set up by an act of its own provincial legislature.

The Canadian Nurses' Association is our medium and spokesman in our relations with other national bodies, and with the International Council of Nurses. We are proud of another achievement in our history and thank all those who helped us so ably.



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EILEEN C. FLANAGAN
Convener
Committee on Legislation, Constitution and By-Laws

The extension to all peoples of the benefits of medical, psychological, and related knowledge is essential to the fullest attainment of health.

— *Constitution of The World Health Organization.*

Nursing Care of Urologic Patients

CHARLES A. CAWKER, M.D.

PRE- and post-operative care of the urologic patient requires constant attention to detail by the nursing, orderly, and urologic surgical staffs.

Pre-operative care of the urological patient has been repeatedly emphasized during the past fifteen to twenty years and cannot be too greatly stressed. The present high standards of urological surgery have been achieved by the broader scope of our laboratories which enables them to give us all the essential laboratory as well as clinical information regarding the patient and to obtain the maximum improvement possible by non-operative means before surgery is instituted.

Post-operative care is of the utmost importance in urologic cases, although it has not been as well emphasized to date. Discharge from hospital does not complete the program of post-operative observation and only the recognition of this fact will lead to more permanent as well as more satisfactory results. This necessitates regimens designed to prevent or diminish the recurrence of renal stones, hygienic treatment in tuberculosis patients, insistence on periodic urethral instrumentation in cases of urethral stricture, observation and correction of ureteral strictures in patients who have had ureterotomy or plastic operation on renal pelvis and/or ureter; continued vigilance over those with malignant or potentially malignant disease; the continued observation and follow-up care to the post-prostatectomy patient to clear the pyuria. Indeed, if at the end of the third or fourth post-operative month the patient continues to have a cloudy, infected urine, or has episodes of post-operative bleeding or recurrent sepsis, it is evident that he is suffering from persistent lesions which must be adequately treated. He requires re-hospitalization for complete urologic examination and operation if necessary.

This prolonged observation and treatment, following many urological procedures, will at times produce permanent improvement in cases, which, without that continued interest, would lapse into a mediocre result.

Let me repeat and re-emphasize—pre- and post-operative care of the urologic patient demands constant attention to detail by nursing, orderly, and urologic surgical staffs. It implies also, by the urologist, careful scientific diagnosis, the accurate comprehension of the pathological condition present, and knowledge of the patient's most vulnerable spot for complications before decision is made as to a definite plan for surgical procedure.

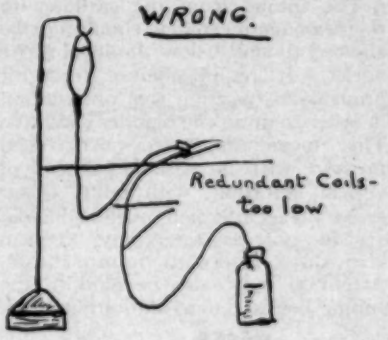
The majority of our urologic patients are in the older age brackets and very many are classified as "poor risks." It is these latter who require urgent, but not often emergency, surgery to restore normal function and to return the patient to normal physiologic equilibrium as far as may be possible. The urologic patient who is "too old for surgery" is quite uncommon, but they do require painstaking, pre-operative care, good anesthesia, planned, gentle surgery, and careful, immediate post-operative care and later follow-up. The physiologic rather than the chronologic age is very important in this class of patient.

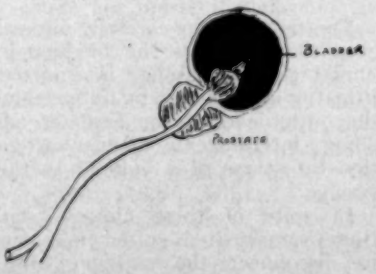
This preamble is to emphasize to you the importance of pre- and post-operative care in the urologic patient. I cannot stress this too much, as it is a fact that is too often not realized by the medical, general surgical and nursing staffs. It is the constant attention to apparently trivial details that can mean success or failure of the operative procedure, life or death to the patient. To give this added, but very necessary, service requires fewer patients per nurse than is usual on medical or general surgical wards.

Competent nursing in urology can

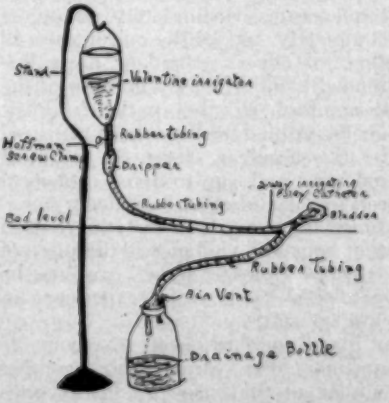
save time in hospital as well as add very greatly to the comfort of the patient. It is illustrated by constant attention to drainage tubes, especially in prostatic cases; promptly calling attention to and/or correcting catheters which are obstructed, adjusting tubing so that no tension is placed on the penile attachment of the catheter; watching for any kinks in the drainage system which are especially likely to occur with change of position by the patient; and attention to the hydrostatics of the various closed sterile irrigation systems commonly in use—intermittent, continuous, and tidal systems—and the very important, diplomatic forcing of fluids. By forcing fluids we mean a fluid intake of 3000 to 4000 cc.—100 to 150 ounces—per twenty-four hours or roughly an eight-ounce glass of water per hour.

To aid in this care, efficient equipment is a *must* and it should be as nearly foolproof as possible. Catheters should all be two-holed, soft rubber—F. 16, 18 and 20, hollow-tip and Coude types. Better still, use the Foley-type bag catheters which allow free drainage of any urethral discharge caused by the inlying catheter, thus lessening the likelihood of such complications as peri-urethritis and peri-urethral abscess formation, and epididymitis. All types should be kept clean at the urethral meatus and removed, cleansed, and replaced every 3-5-7 days. The Foley type may be left *in situ* up to two weeks with no detrimental effects. There is no place on the urologic ward (or any other ward) for catheters that are old, inelastic and soft, easily kinked or with a crack at the end necessitating unsatisfactory makeshift arrangements to connect them to drainage bottles. Suction through old urethral catheters is also quite impossible. Long, redundant coils of rubber tubing, too, are a hazard, but one must be sure to have sufficient tubing to allow the patient freedom of movement. No rubber tubing is kinkproof, but new latex tubing is the least likely to kink. All tubing used should be new; old soft tubing is dangerous. Long loops of tubing should not be drooped below the bladder and bed level, as this requires additional pressure to force the irri-





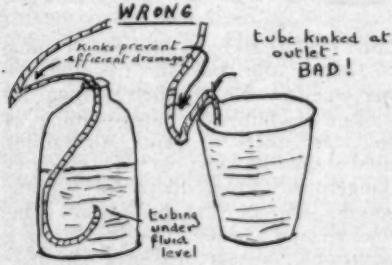
Foley-type catheter with balloon inflated. No penile adhesive necessary.



Apparatus for continuous irrigation of bladder and for intermittent flushing and irrigation of bladder.

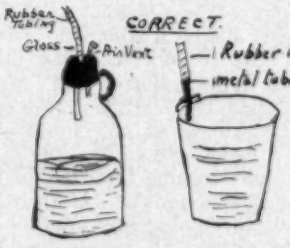
gating fluid up the loop into the bladder. Also, the tubing from the bladder should enter into a clean or sterile receptacle and the outlet of the tubing kept at the top, well above the water level. A pail or bottle may be kept on the floor at the bedside. The force of the siphonage is greater here but it is not sufficient to irritate the patient's bladder.

The tubing from the catheter to the drainage receptacle should not be allowed to sink below the level of its outlet. It requires more force or pressure to override this obstruction in order to drain the bladder contents. This means increased intravesical pressure with increased likelihood of vesical irritation; with reflux upper urinary tract infection (pyelonephritis) or, in post-prostatectomy, it can stimulate renewed hemorrhage. Attention must also be paid to the tubing connected to the outlet vent.



A kink here has caused dire consequences as it completely, or almost completely, blocks the outlet with all the evil effects attendant on a distended bladder, to say nothing of the discomfort to the patient. Post-operative bladders have been ruptured by this accident. Even on the most modern and up-to-date urological services mistakes and accidents sometimes happen. It is for this reason that constant vigilance is the price of safety. "Urologic sense" can only be developed by plentiful experience in urologic surgery.

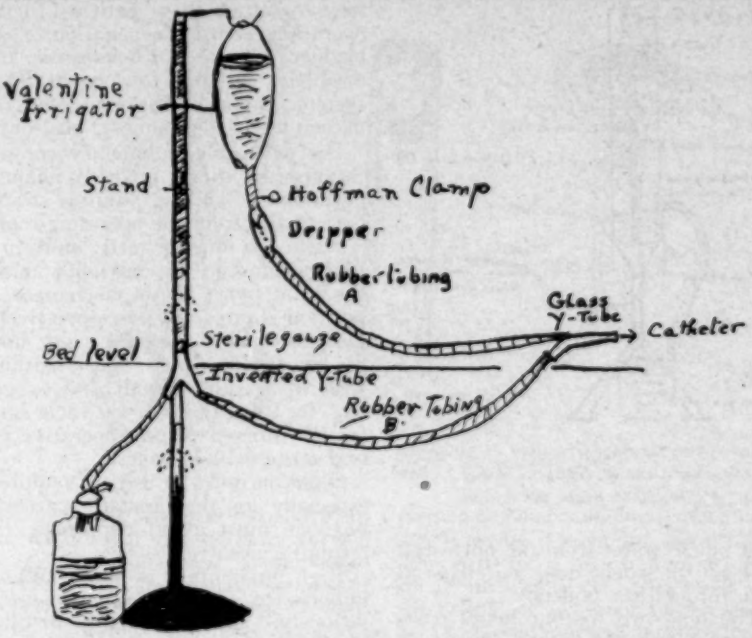
In all our irrigating systems we routinely use a dripper arrangement similar to that used on intravenous sets, or a Murphy dripper can be used. It is only by the use of some such arrangement that an accurate rate of flow can be determined at all times. The rate can easily be increased to flush out the bladder and as readily decreased to return it to the desired continuous irrigation rate. Unbreaching the sterile, closed circuit at the catheter inlet to the bladder to estimate the rate of flow is mentioned only to condemn it. It nullifies the sterile set-up and defeats part of the purpose of the closed circuit. Also, with the dripper arrangement, if all is not well in the bladder, the fluid often backs up into the system and it either stops altogether or slows it down. With the Murphy drip, unless the vent is sealed off, it will cause the water to leak out (for this reason I often close the opening with a piece of flamed adhesive). If this happens, it is a sign of trouble even though the irrigation otherwise appears satisfactory and drainage clear. Three conditions should be suspected:



(1) Clots in the bladder floor, even a few, foul up the inlet and are a cause of bladder spasms, which leads to increased bleeding, etc., plus the danger of chills and fever. This means reflux pyelonephritis has occurred. (2) Acute infection of the bladder. (3) Loop of tubing below bed level.

Treatment is to carefully investigate the status of the bladder by "milking" the tubing, intermittent irrigation and, finally, by unbreaching the outlet end of the catheter and doing intermittent bladder irrigation by means of a bulb or suction syringe.

In spite of these closed irrigation systems it is often necessary to disconnect the catheter outlet for intermittent bladder irrigations. Sterile technique must be observed:

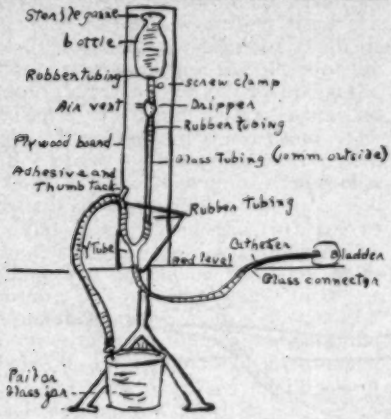


Closed system for drainage and irrigation of bladder (intermittent) — manual control. For irrigation: Pinch off tube B. Release clamp on tube A and allow desired amount to flow from irrigator into bladder. Pinch A and release B to allow fluid from bladder to flow into drainage jar. Repeat until return flow clear. Dripper is not absolutely necessary for intermittent irrigation but is required to convert to continuous or tidal systems. Y-tube in drainage conduit is open to prevent negative pressure and to allow elevation for purpose of decompression.

Sterile hot water (110-115°F); sterile kidney basins; glass connecting-tube kept sterile or replaced by a sterile one; a good rubber bulb syringe of the B/D type (and I mean a rubber bulb with a little life in it for suction); and a wide-bore, powerful suction syringe of the Toomey type to break up and evacuate clots.

These are musts to evacuate the bladder and re-establish our closed system.

A word about irrigating media. Cold or cool solution causes shock to the bladder with resultant irritability and vesical spasm. For post-operative prostatectomies, hot water (110-115°F), as hot as one can stand one's hand in, is best. It is hemostatic for venous and capillary bleeding and does not irritate the bladder, unless too hot. Use in the intermittent or continuous flow systems. How to keep the water heated is a real problem. It can be readily heated up for use in the intermittent systems, but with the continuous irrigation it is a more difficult problem. An electric light bulb, enclosed in a sterile beaker, set in or suspended into the centre of the irrigator, is used in some places. Usually as the water becomes less warm the bladder gradually becomes accustomed to it. It can be reheated by adding hot water to it at intervals. Attempts should be made to keep it as near the optimum temperature as possible. The type of fluid is not important as long as there is plenty of it; 1/10,000 solution of silver nitrate, normal saline and ordinary hot water can all be used. Sterile hot water is as good as any solution and more convenient.

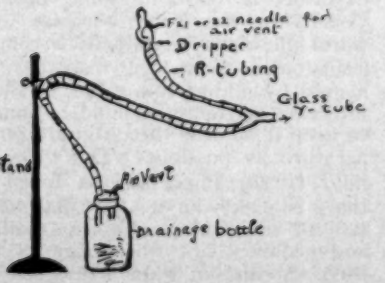


Closed system for tidal irrigation — automatic control (after Cone & Bridges, M.N.I.). Rate of flow: 50-60 drops per minute.

In a pinch, water from the hot water taps can be safely used as it has all been through the boilers.

The first two to four hours post-operative are the most important from the irrigation standpoint. A good, rapid flow of hot solution should be maintained (use a steady stream). Later, when the bleeding appears to be less, the rate can be decreased to 80-120 drops per minute with intermittent rapid flow flushing of the catheter and bladder to be done q. ½ h., q. 1 h., q. 2 h., 5-6 times per day while *in situ*.

If the amount of bleeding does not become less or even appears to increase the urologic surgeon should be notified, as sometimes it is necessary to return these patients to the operating-room for evacuation of the bladder, fulgurate for hemostasis, and reset the catheter for our drainage system. This should be done before the patient has become almost "bled-out."



Conversion to tidal irrigator

Post-operative pulmonary complications are to be guarded against, particularly chilling during transport to and from the operating-room. A warm bed must be ready on return. Flat position in bed, one pillow under the head, with frequent changes of position is preferred post-operatively. Deep breathing exercises every hour are beneficial. We use deep breathing with the carbon dioxide and oxygen bag for five minutes of each hour for the immediate post-operative period up to 8-10-24 hours.

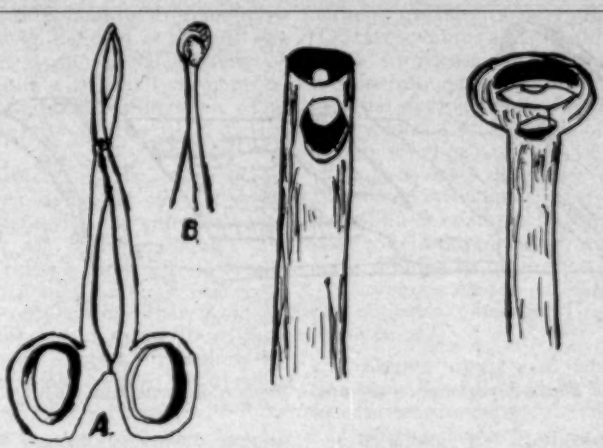
Sedation must be used as required, especially for the prostatic patients, but one must avoid depressing the respiratory centre.

High fluid intake is of the utmost importance — by mouth or intravenously. Glucose 5%, in distilled water, is safer to use in forcing fluids intravenously for these patients, provided the blood chlorides are within normal limits and no acidosis is present. This state is evidenced by a decreased carbon dioxide combining power, in which case we use glucose, saline, and/or 1/6 molar lactate solution. Amigen is used in smaller quantities daily in the old patients.

Even small blood loss is poorly tolerated by elderly persons and blood transfusion may be given to replace plasma proteins, replace blood loss, decrease chance of infection and generally to shorten the convalescence.

Old people are especially susceptible to suggestion. Adverse comments should be carefully avoided and encouragement given at every opportunity. The stay in bed is shortened to a minimum. While the patient is confined to bed it is important to change position often and to move the legs about. Where convalescence is long drawn out and progress slow, marked improvement often follows a complete change of surroundings.

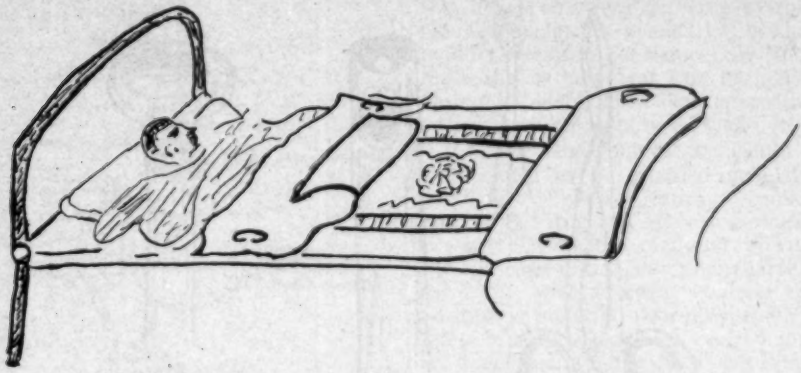
Frequent changing of damp or wet



Two views of clot forceps — Freyer tube — Pezzar tube.

dressings and sheets is necessary for the comfort of the patient, as well as for the atmosphere of the ward or room. This is especially important to prevent the chilling of the patient, thus rendering him more liable to complications and causing soggy skin. Routine skin care in these patients assumes more importance when one realizes that the skin covering these tired old backs is prone to break down even under the best of conditions and the likelihood is markedly increased if the patient is allowed to linger on wet sheets and dressings.

Most of our suprapubic prostatectomies are done in one operation. Bleeding is controlled by Foley catheter F. 24, 75 cc. bag perurethra, and an open-end Pezzar tube (catheter) in the bladder suprapubically as a safety valve. This system utilized the drainage and the irrigation systems already described and as used in the perurethral and perineal prostatectomy cases. There are exceptions and occasionally the patient may return to the ward with a Freyer tube in the bladder with open drainage on the dressings (or a Marion tube). Frequent evacuation of clots through the Freyer tube by means of sterile clot forceps (small sponge or ovum forceps) is done to ensure an empty bladder to control bleeding. Here, frequent changes of the dressings and sheets is of paramount importance. This calls for a bed-draping arrangement in which the patient is not disturbed or exposed unnecessarily and yet ready access is provided to the operative site. The upper drape consists of a warm, flannel nightingale worn over the gown, to which a dressing towel is fastened with safety-pins. This drape remains in position between dressings. The lower drape consists of a flannelette sheet folded lengthwise and placed under the upper bed-clothing. A dressing towel is pinned to the upper edge. When the dressing is finished, the bed-clothing is drawn up over the patient. A bedside tray is arranged with sterile clot forceps in a jar of sterile water, sterile dressings in covered bowl, sterile kidney basin, sterile scissors and forceps. All prostatic patients, whether packing or catheter is used to control bleeding, will, for the first 24-36 hours, complain of a desire to void or move the bowels. After careful check to see that all apparatus is in order, explain the situation to the patient and relieve the symptoms with sedatives. If this urge continues, the patient strains to void or to move the bowels. This stirs up fresh hemorrhage leading to vesical spasm with



Drape arrangement for suprapubic prostatectomy with Freyer tube.

increased bleeding — a vicious circle.

The use of enemata too soon after a prostatectomy may encourage hemorrhage. Most patients have had a thorough cleansing pre-operatively and bowel elimination can be safely resumed on the third or fourth post-operative day with use of divided doses of a mild cathartic such as milk of magnesia, mineral oil, or magnolax. If no bowel movement results then an enema may be given. In perineal cases no enema is given for 5-7 days. Many urologists use a low-residue diet in all prostatectomy cases so that there is less need for bowel elimination post-operatively. When enemata are given, use a soft rectal tube or, better, a urethral catheter to avoid injury to the rectal wall adjacent to the prostatic bed. Belladonna and opium suppositories for pain and the use of a urethral catheter per rectum for gas, if carefully inserted, may be permissible at times.

Abdominal distention is treated with hot abdominal stupes or heat cradle, prostigmine per hypo. In serious cases the Miller-Abbott tube, plus Wangensteen suction, may have to be used.

Nausea and vomiting or hiccoughs are frequently due to the decrease in kidney function which must be attacked with intravenous fluids. Dilatation of the stomach can be ruled out or treated by Wangensteen suction drainage through Levine or Miller-Abbott tube. The use of the carbon dioxide and oxygen bag provides best treatment for hiccoughs not due to poor kidney function.

Kidney and ureteral surgery: There is less likelihood of post-operative abdominal distention if cathartics are given 36-48 hours pre-operatively, followed by a cleansing enema. Fluid intake should be forced for several days prior to the operation for all urologic patients. Prostigmine 1 cc. hypodermically q. 4 h., started 12-24 hours before and continued 48-72 hours post-operatively, gives excellent results.

Unless the patient has nephrostomy or ureterostomy tube *in situ*, he should lie on the side of operation. He may lie on his back, with icebag under C.V. angle of operated side. This last position embarrasses neither side of chest.

Record fluid intake and output (where possible) on all urologic patients: Fluids may be given freely by mouth immediately on return; enemata as necessary for gas pains. Adequate sedation is required for 24-48 hours post-operatively, after which the wound rapidly becomes less sore, especially if patient moves around.

Post-nephropexy: The foot of the bed is elevated for 14-21 days. The patient may lie on the side of operation, on the back or on the abdomen, but not on the unoperated side.

Nephrostomy and ureterostomy tubes must be handled as already described for sterile closed system of irrigation but with small amounts of fluid used with each increment. The normal capacity of the renal pelvis is 7-12 cc. Special care must be taken to avoid any drag or pull on these tubes as it is very painful to the patient and the tubes may be pulled out of position. Should this occur, the tubes cannot be re-inserted, consequently they must be removed. Too early removal or other accident to these tubes can mean the difference between success or failure of the operative procedure; between a good kidney or the loss of a kidney.

Cystoscopy and retrograde pyelography: This is the backbone of our diagnostic procedures. A sterile specimen of urine is required on all patients and should be collected in sterile containers and examined while fresh. In the male, 2-glass urinalysis is usually done. In the female patient, a catheter specimen is necessary to avoid contamination of the specimen by vaginal secretions. Many urologists insist on hospitalization for a period of twenty-four hours following post-retrograde pyelography even when done under local anesthesia. Observation and care during that period certainly will diminish the chance of suppression of urine, rise in temperature, or discomfort due to instrumentation. The veru and trigone are very sensitive and irritation causes frequency and burning which can be very acute in some patients. Catheterization of ureters can cause irritability of the ureteral mucosa with attacks of colic. This is thought to be due to the mercuric compounds used in sterilization reacting with the iodides of the opaque medium, precipitating mercuric iodide which causes the post-cystoscopic colic. To avoid these complications as well as to treat them, a good fluid intake is required both before and after. In addition, rest in bed, hot sitz baths or hot rectal irrigations, and belladonna and opium suppositories will assist in avoiding troublesome symptoms. Urinary analgesics as Pyridium and Tr. Hyoscyamus are valuable in treatment. Patients admitted with colic require frequent sedation, forced fluids, and the sieving of all urine for calculi or crystals. Local heat is often valuable in relief of pain.

Acute urinary infections: The usual treatment includes bed rest lying flat, forced fluids, sedation as needed, local heat to relieve painful symptoms, and sulfonamides as ordered.

Neurogenic bladders: These are difficult subjects to handle. Urologic care is aimed at:

1. Keeping urinary tract infection at a minimum. Renal insufficiency is one of the common causes of death.

2. Keeping bladder volume or content within normal limits. Back pressure changes in the mid and upper urinary tracts follow prolonged distension or residual urine.

3. Every effort must be made to recognize automatic phase which permits removal of catheter and drainage tubes and allows intermittent voiding. Morale is raised, ambulatory existence is made easier and progress better when more normal bladder function resumed.

The use of F. 16, 18 and 20, 5 cc. Foley-type urethral catheters for urethral drainage ensures less danger of complications. Change the catheter every 7-14 days. Cleanse a closed system once a week. Use tidal drainage and irrigation whenever possible. Periodic urinalysis, culture and x-rays for stones, and a study of the function and appearance of urinary tract help in the diagnosis. Transurethral prostatic resection of the contraction of the vesical neck and bar formation may be necessary to re-establish the optimum bladder function. A Cunningham clamp and a rubber urinal provided for each patient instils confidence. All these cases must be individualized.

No claim to originality is made for this article. It is a composite of the writer's experience at Shaughnessy Hospital; as resident in Urology, with Dr. Emerson Smith and associates at the Royal Victoria Hospital, Montreal; and from observations made in urological clinics in this country and the

United States. I am especially indebted to Dr. Clyde L. Deming, Yale University, New Haven; Dr. George C. Prather, Boston; Dr. Frederick C. McLellan, New York; Dr. Reed M. Nesbit, University of Michigan, Ann Arbor; Dr. Elmer Belt, Los Angeles; the late Dr. Oscar Mercier and associates at the Hotel-Dieu, Montreal; and Dr. Robin Pearse and associates of the Toronto General Hospital.

Prostatism

EVELYN MYERS

To understand this condition we must first have the necessary knowledge of the anatomy and physiology of the prostate gland. The prostate is a male sex gland resembling a horse chestnut in shape and size. It is located in the neck of the bladder and extends into the posterior urethra. It is this situation which makes it become an obstructive entity when it enlarges. In the male embryo, the prostate develops in five lobes: one anterior, two lateral, one middle, and a posterior lobe. The embryonic anterior lobe in front of the urethra atrophies until, in adult life, it is little more than a band of tissue. The two lateral lobes are situated on either side of the urethra, and the middle lobe forms a wedge-shaped portion between them. The posterior lobe is situated below the middle lobe in close relationship with the rectum. The function of the prostate is to produce a thin opalescent fluid which serves to prolong the life of the spermatozoa.

Enlargement of the prostate is a disease of later life, occurring most frequently between the ages of fifty and seventy. The enlargement may occur in any one or in all lobes of the prostate, but usually occurs in the median or lateral lobe. Prostatic hypertrophy falls mainly into two groups: (1) benign hypertrophy; (2) malignant hypertrophy.

The complaints of the patient all arise from the enlarged gland interfering with the passing of urine: e.g., frequency, nocturia, alterations in the act of micturition such as hesitancy, urgency, difficulty in starting and stopping the stream, and diminution of the stream. There may be burning on micturition, pain in the lower back, and in the backs of the legs, hematuria, or the obstruction may be complete giving the patient acute retention of urine.

If the patient is allowed to continue with these symptoms, and does not receive a thorough urological investigation and indicated treatment, complications will develop. First, there will be a marked hypertrophy of the bladder wall due to the greater force necessary to empty the bladder past the obstruction. This has the effect of increasing obstruction at the point of outlet of the ureters into the bladder, thus rendering difficult the function of the renal pelvis and ureters in expelling urine into the bladder. This, accompanied by the increasing failure of the bladder to empty itself, results in back pressure upon the kidney with dilatation of the ureters and of the kidney pelvis (hydronephrosis). Owing to this dilatation, there will be compression of the renal parenchyma and atrophy, with the resultant loss of ability to secrete toxic end-products of metabolism. These, being retained, will cause the patient to pass into a semi-uremic or uremic state. This condition is called uremia and is recognized by: (1) dry tongue; (2) dry skin; (3) emaciation; (4) anorexia; (5) lethargy.

If, when the patient is admitted to hospital, his complaints are in keeping with those already mentioned, a routine investigation is carried out:

(1) A urinalysis is done. (2) Rectal examination will reveal enlargement of the lateral and posterior lobes. (3) He is catheterized for residual urine, and, if excessive, a decompression apparatus may be set up to provide

temporary drainage, and to improve the bladder tone. (4) Blood is taken for the determination of the non-protein nitrogen and urea nitrogen. (5) Unless contra-indicated, a cystoscopic examination is carried out, in which the exact state of the bladder and the prostate is observed. The ability of the kidneys to secrete is tested by intravenous injections of indigo-carmine, and retrograde pyelograms are taken of the kidney, pelvis, and ureters if necessary. Intravenous pyelograms are also very valuable in studying the form and position of the kidneys and ureters, and to determine the function of the kidneys.

These examinations indicate the operation to be carried out in any type of "benign hypertrophy." The prostate may be removed by a variety of methods: (1) suprapubic prostatectomy; (2) retropubic prostatectomy; (3) perineal prostatectomy; (4) transurethral resection of the prostate.

SUPRAPUBIC PROSTATECTOMY

This is usually a "two-stage" operation, and is undertaken in patients in whom prolonged drainage is required on account of extensive damage to kidney function, or on patients for whom drainage by catheter is unsatisfactory.

The first stage consists of opening the bladder, and inserting a mushroom catheter, about which the bladder and the wound are then closed. This drainage is continued until the general condition of the patient is entirely satisfactory. Sometimes the patient is allowed to leave the hospital and continue with his suprapubic drainage for some months, and then return for the second stage. In ordinary cases, the second stage follows the first stage in ten to fourteen days.

Nursing care: The nurse should get the drainage equipment ready for use while the patient is in the operating-room. It consists of drainage bottle, rubber tubing, glass connecter, sterile irrigating solution, and bulb syringe. When the patient returns to the ward, the suprapubic catheter is immediately connected to the drainage bottle, and irrigated every hour or more often according to the amount of bleeding. The head of the bed should be elevated as soon as possible. Fluids should be forced as soon as they can be tolerated, and an accurate fluid intake and urinary output record charted. Traction on the catheter is prevented by fastening the drainage tubing to the bed with a safety-pin. By fastening the abdominal binder on the same side as the drainage tube, there will be free drainage of urine from the catheter.

The dressings are changed twice daily, or more often if required. The incision is cleansed with alcohol and painted with mercurochrome solution. The cigarette drain is usually removed at the end of twenty-four hours, the clips are removed on the fifth day, and the retention sutures are removed on the tenth day.

A scrotal support is a very valuable aid in preventing epididymitis. A vasectomy, however, is usually performed during the first stage of the operation to prevent this inflammation.

For the second stage of the operation, the patient is prepared in the usual manner for the operating-room, the suprapubic catheter being clamped off. This operation consists of the enlargement of the opening through which the suprapubic catheter has passed, and the enucleation of the gland through this wound. The bleeding is controlled by the introduction of a Pilcher's Bag, and pressure is applied by filling the bag with sterile water. Tension is applied by the use of the "wire cage," supported under the scrotum.

As soon as the patient returns to the ward, the nurse should be on the alert for complications, the first and most dangerous being shock. Because of advanced age, operative trauma, and loss of blood, prostatic patients will go into shock very quickly. The treatment is the same as for all surgical shock. Hemorrhage is another dangerous complication. Traction on the tube coming through the urethra will probably check the bleeding.

Four hours after the patient returns to the ward, the tension is somewhat released by removing the wire cage. We must watch very closely now for

hemorrhage. Eight hours following the operation, the water is released from the Pilcher's Bag by cutting the silk from the tube. Dressings must be changed frequently, as the urine drains into them. Fluids are forced, and the fluid intake and urinary output must be accurately recorded. Twenty-four hours after the operation, the Pilcher's Bag is removed by the interne. The nurse must have a tray ready for him, consisting of hydrogen peroxide, sterile dressing forceps, and emesis basin. Again, we must watch carefully for hemorrhage. Now the time has arrived for the setting up of the "electric pump," a suction apparatus used in siphoning the urine from the bladder through the suprapubic wound into a drainage bottle. This is left in place until the wound begins to close, and the patient starts to void. Ordinarily, he should be ready to leave the hospital within two weeks following this operation.

Retropubic Prostatectomy

This is a one-stage operation in which the prostate is removed through an incision made through the prostatic capsule below the bladder area. Unlike the suprapubic prostatectomy the bladder in not opened. A two-way irrigating Foley catheter (75 cc. balloon capacity) is usually inserted in the bladder *per urethram*.

On return to the ward, a continuous bladder irrigation is set up, consisting of a Kelly bottle, rubber tubing, Murphy drip, glass connecter, and drainage bottle, and using the solution as ordered by the urologist. This is usually continued for ten days, the catheter then being removed (by first removing the water from the balloon). The incision is cared for as in the suprapubic prostatectomy. Special attention should be given to the forcing of fluids, and an accurate record of the fluid intake and the urinary output recorded.

These patients are generally allowed out of bed early, before the catheter is removed. Before leaving the hospital urethral dilatation is carried out by the "passing of sounds." The hospitalization period is two to three weeks.

Transurethral Resection

In this operation, the obstructive tissue of the prostate gland is removed by means of electrically-lighted instruments introduced and operated through the urethra. Spinal anesthesia is the most common choice of anesthetic used.

The patient returns to the ward with a Foley catheter inserted into the bladder through the urethra; this catheter is immediately connected to a drainage bottle. It is the responsibility of the nurse to see that the catheter is irrigated and free drainage allowed at all times. In order to maintain free drainage, the catheter must be irrigated every fifteen minutes, or more often if the bleeding is excessive. The choice of irrigation solution rests with the surgeon. The irrigation may be carried out by the use of a bulb syringe, or by the method more commonly used today, consisting of a Kelly bottle, Murphy drip, Y-glass connecter, rubber tubing, and two shut-off clamps. In this latter method, by clamping off the tube leading to the drainage bottle, and allowing 50 cc. of irrigating solution to enter the bladder, and remain there for fifteen minutes, very good results have been obtained. If sufficient time is spent on the patient's return to the ward in irrigating the catheter continuously until the return flow becomes quite clear there is much less danger of clot formation. On the second day, if there is very little bleeding, irrigations at half-hour intervals should be satisfactory. The catheter is removed on the morning of the third day if there is no bleeding.

The forcing of fluids is very important, also the record of fluid intake and urinary output should be charted. The patient's head should be elevated as soon as the effects of the anesthetic have worn off, and he should be encouraged to turn freely from side to side. These patients, being elderly, are particularly susceptible to congestion of the lungs. If no complications occur, they are generally allowed up on the fourth or fifth day. The amount of residual

urine is tested on the eighth day and, if excessive, sounds are passed on the tenth day. The patients are usually ready for discharge from hospital on the thirteenth day.

Perineal Prostatectomy

This type of operation is performed less frequently but, by this method, the prostatic gland is removed through an incision made in the perineum.

The patient usually returns to the ward with a urethral catheter draining the bladder. Unlike the previous operations, the catheter should not be irrigated as freely, but only enough to keep it open because of the danger of the fluid leaking through the perineal incision. The catheter usually remains in the bladder until the perineal wound is completely healed.

Malignant Hypertrophy

This is determined by rectal examination which will show the prostate to be very hard and fixed with a moderate degree of enlargement; or biopsy which will show the infiltrating carcinomatous tissue. In this disease there is a tendency to metastasize to the bones, chiefly those of the pelvis, sacrum, and dorsal spine. Therefore, an x-ray is always taken of these areas. Blood is also taken for acid and alkaline phosphatase tests, which are usually elevated in this disease particularly when metastases occur. Hence, on this basis, the diagnosis is made.

Unfortunately, this is not a field in which surgery can offer any considerable chance of cure. The obstructing portions of the growth are removed by means of transurethral resection. A bilateral orchidectomy is performed, which is often very valuable in relieving the severe pain of bone metastases. The operation may be followed by x-ray therapy, and the administration of stilbesterol. This treatment offers relief of symptoms for a time. It is surprising how long many of these patients will carry on with a prostatic carcinoma. Malignancy in this area is often much slower in producing a fatal termination in other tissues of the body.

Summary

1. In any bladder operation, it is extremely important to keep the catheters free from occluding blood clots.

2. It is extremely important to keep any patient bordering on a uremic state, or with decreased urinary output, on a high fluid intake.

3. These patients, being elderly and showing some senile mental changes, need very close observation and a great deal of cheering in order to see that they are making satisfactory progress, and that they are imbued with the desire for recovery.

Manitoba University School

Nurses throughout Canada will be glad to learn of the decision of the Board of Governors of the University of Manitoba to continue the School of Nursing Education. This western school is greatly needed as it supplies public health nurses, teachers, and supervisors for a large section of the prairies. Public interest has been tangibly expressed by the provision of several worthwhile scholarships. Information concerning these scholarships may be obtained from the Director of Nursing Education, University of Manitoba, Winnipeg, or from the Executive Secretary, Manitoba Association of Registered Nurses, 214 Balmoral St., Winnipeg.

Preview

The nurse who has lived all her life among the niceties of a town or city home has very little conception of the rugged existence of some of our fellow countrymen who choose to live in the more remote areas of our vast land. Yet those people are as much in need of nursing care and health teaching as the families in our midst. The Canadian Red Cross Society has long recognized this need and has provided care through the outpost nursing services. One of their staff, **Muriel I. Schonberg,** gives you some of the plain facts in her gripping article which will be published on the Public Health Nursing Page next month.

New Methods of Treatment for Venereal Disease — Gonorrhea

B. D. B. Layton, M.D.

A consideration of recent advances in treatment methods for gonorrhea in both male and female brings to light a succession of most interesting developments. One has only to look back over the past several years to appreciate what remarkable progress has been made in this field and, with the promise of what present treatment procedures appear to hold, confidently be reassured that the future of gonorrhea therapy is highly optimistic.

To comprehend the full significance of the progress made, a brief glance into the past provides a rather striking comparison with modern methods. In both male and female gonorrhea, in earlier days, the accent was on local treatment. Instillations and irrigations in the male urethra with various chemicals and multiple prescriptions incorporating urinary antiseptics and sedatives formed the basis of the medical treatment.

In the female, douches employing various types of antiseptic solutions, topical applications of strong chemicals, medicated tampons, urethral injections, and local heat applications by hip and sitz baths, or by somewhat complicated intravaginal contrivances, all have found varying degrees of popularity at one time or another.

In reviewing these earlier methods one does not, by any means, hold them in ridicule. To the contrary under certain circumstances and in certain complications the employment of effective local measures is a valuable adjunct. In the main, however, the treatment of gonorrhea in both male and female has resolved itself into the logical conclusion that any procedure which will support the natural recuperative processes of the body, both local and general, without further injuring the affected tissues or interfering with free drainage of infected secretions, should be considered of value. Conversely, any agent such as a strong chemical or instrumental interference with acutely influenced structures is, in the opinion of most thoughtful urologists and gynecologists, to be rigidly avoided.

It is interesting to note that the general measures recommended in the past are quite consistent with accepted modern procedures. Even under our most advanced methods of treatment, increased rest is considered beneficial regardless of the stage of the disease. In the female, especially, bed rest is most helpful. General supportive nursing procedures contribute much to recovery, particularly if complications ensue. To mention briefly the diet — the patient is advised to partake of a soft, easily digestible diet while greatly increasing the intake of fluids and rigidly avoiding condiments and highly seasoned foods. Abstinence from all types of alcoholic drinks is imperative and the patient should be warned that all forms of sexual excitement are likely to be harmful.

The Sulfonamides

With this brief consideration of past practices and continuing general measures, one turns to review the first of what might be described as the two major steps forward in gonorrhea treatment — the sulfonamide era. Commencing with the introduction of sulfanilamide, and followed by the rapid development of similar compounds of this group, a wave of enthusiasm and optimism was stimulated. There was great promise that at last this obstinate infection was to be brought under proper therapeutic control. We know now

that such was, unfortunately, not entirely the case and that the original promise offered by the sulfonamides has not been wholly fulfilled.

Four sulfonamide compounds have been employed in the treatment of gonorrhea: sulfanilamide, sulfapyridine, sulfathiazole, and sulfadiazine, their development occurring in that order. The relative effectiveness of these drugs now appears to be fairly well determined and the consensus rates their therapeutic efficiency in reverse order of their development. This view is supported by the results of a large number of clinical studies which have been successfully concluded. In considering the employment of sulfonamide compounds for the treatment of gonorrhea, sulfadiazine and sulfathiazole are the drugs of choice, the latter being only slightly less effective. Both give better results and are better tolerated than are sulfanilamide or sulfapyridine. It must be remembered, however, that all sulfonamides carry the risk of toxic phenomena.

As a further observation, resulting from wide clinical experience with the chemotherapy of gonorrhea, it is recommended that cultures of the gonococcus be employed for diagnosis and the determination of cure, wherever possible, in preference to smear examinations. It has also been determined that in the female a condition when only apparently cured is most likely to recur following the menstrual period. Obviously then in the determination of cure the likelihood of dependable smear and culture examinations is greatest when such tests are made immediately following the cessation of the menses.

Another interesting feature was brought out in a study dealing with the investigation and treatment of a large group of proven or suspected prostitutes infected with chronic gonorrhea. It was found upon examination of 615 women, all culturally positive, that only 20 per cent were noted as having clinical evidence of gonorrhea at the time of the initial examination. Repeated examinations, however, revealed a greater percentage to have clinical signs of the disease. This finding in itself serves to emphasize a most important aspect of venereal disease control, i.e., the clinical examination of the suspected individual without supportive laboratory evidence is highly unreliable and cursory examination of individuals, such as prostitutes and promiscuous amateurs, is of little value in detecting evidence of the disease.

In recent years there have been increasing indications that there are certain strains of gonococci which do not respond to the effect of the sulfonamides, the so-called sulfa-resistant organisms. It has been noted, particularly if treatment is not carefully carried out with adequate dosage, that gonococci tend to become resistant to the curative effect of the drugs to such a degree that considerable difficulty may be encountered in using these compounds effectively.

By way of explanation, it has been suggested that the administration of inadequate doses of sulfonamides, while not only failing to destroy the gonococcus, have also had the doubly unfortunate effect of building up its resistance to the drug. Thus, at a later date when doses are administered which originally would have been adequate, not only do they fail to destroy the germ but also further stimulate its increased resistance. As evidence of this situation accumulated, it became apparent that other means of attacking these sulfonamide-resistant organisms had to be developed to prevent their widespread dissemination. One of these procedures is described as the fever treatment, or hyperpyrexia.

Fever Therapy

The treatment of gonorrhea by elevation of the body temperature to levels comparable with high fevers probably resulted from the observation that during prolonged febrile reactions due to other conditions, such as pneumonia, typhoid fever, etc., gonorrheal discharges became reduced or completely disappeared. This gave rise to much study and experi-

mentation, primarily to determine the level and duration of fever necessary to accomplish this result and, secondly, to evolve a satisfactory method of providing such a fever.

Regarding the first factor, there was at first a remarkable diversity of opinion on the desired level. After a great deal of experimental study, however, it was determined with a fair degree of certainty that at 106.7° F. the great majority of strains of the gonococcus are killed in from five to fifteen hours. One group of investigators studied 130 different strains of the germ and found that they all succumb at this temperature.

Many methods were devised to elevate the temperature. In Germany, in 1912, prolonged immersion in hot water was tried but, as Pelouze points out, "beyond killing a number of people who otherwise might have lived many years this procedure got nowhere." Malaria inoculations were attempted with some success but because the malaria was harder to bear and was more dangerous than the gonorrhea it has been largely abandoned.

The search for other methods of raising and regulating body temperatures resulted in the development of several different varieties of fever cabinets, the most widely known and studied probably being the Kettering Hypertherm. By this device, body temperature can be raised to the desired level and maintained there for a prolonged period. Of the many different treatment programs described most follow the pattern of raising the body temperature to 106° to 107.2° F. for a period lasting from five to ten hours and repeating every few days as required. The number of such treatments may range from two to twelve or more.

That this procedure is rigorous is quite obvious. To quote Pelouze in reference to hyperpyrexial treatment: "It is an ordeal in which many patients go dangerously close to the pearly gates, some hear the hinges creak and some just stop hearing forever."

In summing up the status of fever treatment the recommendation of Carpenter and Warren seems to express the popular opinion best: "The method should be reserved for the treatment of the graver complications of gonorrhea and those patients who have resisted cure by other less dangerous and trying therapeutic measures."

Penicillin

Prior to the development of penicillin, hyperpyrexia was used chiefly for the treatment of cases of gonorrhea resistant to sulfonamides and other forms of treatment. However, since penicillin has shown such remarkable, effective results in these cases the hypertherm has generally fallen into disuse.

The second major advance in the progress of modern gonorrhea therapy consisted of the discovery and clinical application of the most famous of all the so-called miracle drugs — penicillin.

While still exhibiting several uncertain features, the penicillin treatment of gonorrhea has now established itself as a highly effective, rapid, and non-toxic procedure. The dosage level of the drug appears to have become fairly well fixed and the major consideration remaining at the moment concerns the best schedule for its administration.

These conclusions have not been reached as rapidly and as easily as one might suspect. The scope of the clinical research carried out is rather staggering and thus is difficult to condense in a brief review. It should, however, be interesting to touch upon the general features of the major developments, as they have occurred, up to the stage of the most recently published observations on this drug.

In the initial studies conducted, the tendency was toward the administration of total doses considerably smaller than the quantities which now appear to be adequate. The results were, on the whole, quite satisfactory, but since higher cure rates were achieved by increasing the total quantity of the penicillin, other schedules of treatment were

investigated in which progressively larger amounts were administered. This led to the determination of what is now accepted as the adequate dosage level.

To illustrate the progress of these studies during the past few years the following reports are selected more or less at random. In a group of 450 patients treated in the U.S. Army, treatment was administered according to three schedules. In the first, 105 patients were treated with a total of 160,000 units of penicillin with a 2 per cent failure rate. In the second group of 112 patients, to whom 100,000 units were administered, the failure rate was 9.8 per cent. In the third group, 233 patients were treated with a total of 50,000 units and 23.6 per cent of these failed under treatment. Of those treatment failures on the three schedules further treatment with larger doses was successful.

In 360 male patients suffering with sulfonamide-resistant gonorrhea, another investigator reported the results of nine treatment schedules, including total doses from 35,000 to 160,000 units of penicillin extending over periods from six to forty-five hours. The over-all cure rate was 88.8 per cent and re-treatment of the thirty-four failures with 100,000 units cured all but three who were later cured by a third course of 160,000 units.

Employing a total dosage of 200,000 units, Heller has recently reported that in 398 patients, white and negro, male and female, from 94 to 96 per cent of the cases were cured.

As a result of this and other published studies in which a similar amount of the drug has been administered, it becomes increasingly apparent that the adequate treatment of gonorrhea with penicillin in aqueous solution now appears to require a total dosage of 200,000 units or more. While the results of certain investigations, in which slightly smaller doses were employed, present a higher percentage of cures, in considering the overall picture and the importance of permanently eradicating the infecting organisms, the administration of the larger dosage of penicillin is recommended.

The next significant step to be taken in the progress of penicillin therapy was aimed at prolonging the effect of a single large dose of the drug, i.e., a one-injection treatment. To determine a satisfactory delaying medium, Romansky investigated the effectiveness of suspensions of penicillin with a variety of substances, such as refined peanut oil, sesame oil, cotton-seed oil, corn oil, castor oil, olive oil and protamine zinc. Although each of these was found to exert a noticeable delaying effect they were not considered entirely satisfactory and further study was necessary before the combination of penicillin with peanut oil and beeswax (POB) was elaborated and adopted as a satisfactory medium.

Employing this mixture clinically, Romansky reported on a series of 175 cases of gonorrhea in males treated with single injections of penicillin in peanut oil and beeswax suspension. Seventy-five patients received a single injection of 150,000 units and no failures were encountered. One hundred patients received 100,000 units in one injection with a cure rate of 93 per cent. The seven failures responded to a second single injection of 150,000 units of penicillin. This mixture has produced no abnormal reactions either locally or constitutionally.

The original work by Romansky has been confirmed by a number of investigators. Van Slyke and Heller reported the results of the study of 1,060 patients, each of whom received a single intramuscular injection of 200,000 units of POB. Ninety-two per cent of the cases were classified as cured following the treatment.

Another type of delaying medium which has been studied consists of peanut oil and falba, a lanolin-like substance. The product has a viscid consistency which becomes liquid when warmed. Mixed with penicillin in aqueous solution an emulsion is formed which may be injected with ease.

Studying the clinical effectiveness of this emulsion Cohn found that, following the administration of a single injection of 150,000 units of penicillin in peanut oil and falba, 101 out of 105 patients with gonorrhea were cured. No untoward local or systemic reactions were observed and the patients whose infection failed to respond to the first course were subsequently cured by a second identical course of therapy or by using larger amounts of penicillin than administered initially.

The further search for easy, simplified methods of administering penicillin has resulted in the study of the effectiveness of the drug taken by mouth. While it is known that penicillin is readily destroyed by the gastric juices recent reports point to possible measures which will overcome this obstacle to oral administration, i.e., the use of the so-called buffered preparations which resist the destructive effect of the acid stomach juices.

In one study it was found that, in order to obtain an adequate concentration of penicillin in the blood, from three to four times the amount of the drug had to be given by mouth as is ordinarily administered by injection. Later reports appear to be more favorable but at the moment the status of this procedure is still undetermined and thus awaits additional investigation.

Ophthalmia Neonatorum

Turning briefly to the consideration of one of the more pitiful conditions caused by venereal infections, a study of 1,176 individual blind persons in Massachusetts showed that in 128 cases, about 11 per cent of the total, the blindness was due to syphilis. In thirty-two cases, about 2.7 per cent, the blindness was caused by ophthalmia neonatorum resulting from gonococcal infection.

This figure is consistent with other reported and somewhat more general observations attributing 2.4 per cent of all blindness to the condition. Thanks to Credé, who over sixty years ago systematized and published a method of preventing ophthalmia neonatorum by the simple installation of silver nitrate drops into the eyes of the new-born babies, the condition which once was responsible for 30 per cent of all cases of blindness has been reduced to its present level.

It cannot be said, by any means, that all danger from this disease has been eliminated. Unfortunately Credé's prophylaxis and prompt treatment of cases does not strike at the root of the evil. For example, it has been found that in spite of the routine instillation of silver nitrate into infants' eyes at birth, the New York City Health Department reported 213 cases occurring between 1938 and 1942. To be absolutely safe from the blinding danger of the gonococcus, gonorrhea itself must be eradicated.

With earlier therapeutic measures the disease was prolonged, the treatment exhausting and conplications frequent, often resulting in blindness. Fortunately, sulfonamide therapy was found exceedingly beneficial in this condition. As an example, in one study employing sulfathiazole orally, all babies tolerated the drug well, the duration of symptoms and positive smears was only one to four days, and the duration of illness in the total group ranged between one and forty-six days. All infants were observed in the hospital approximately one week after cure and there were no complications or relapses during the follow-up period.

It is apparent that with the advent of the sulfa drugs the treatment of ophthalmia neonatorum was greatly improved. The administration of these drugs and the installation of sulfa ointment did much to shorten and simplify the treatment. However, the discovery of penicillin has revolutionized the treatment of this disease and, where the sulfonamides cleared the condition within days, penicillin clears it within hours.

It should be stated that penicillin therapy of gonorrheal ophthalmia is not yet sufficiently well standardized for any explicit suggestions to be given for its general use. Ex-

perience to date, however, is exceedingly optimistic.

Two points are essential in the treatment of ophthalmia with penicillin; adequate concentration of the drug and frequency of application. According to the experience encountered in an institution in England the most consistent results are obtained when a solution of 2,500 units per cubic centimetre is used. With regard to frequency of treatment, progressive improvement in results was noted when the interval between the instillations was reduced from one hour to one-half hour and still further to five minutes. In the most recently treated cases the penicillin solution has been instilled at intervals of one minute and generally speaking all pus can be suppressed within thirty minutes. Thereafter a simple conjunctivitis, giving no anxiety, is left which heals within two or three days.

Despite these remarkable results the fact remains that in this, as in all other diseases, prevention is better than cure and the careful application of prophylactic measures and suitable nursing techniques will best reduce the hazards presented.

Dual Infections

Numerous workers, carrying on intensive studies of the treatment of venereal disease with penicillin, have brought to light a most interesting observation. It is obvious that in acquiring gonorrhea any individual may have simultaneously contracted syphilis. Both diseases respond to penicillin. In treating the gonorrhea, which would probably be the first to develop clinically because of its shorter incubation period, in some instances it has been observed that the total dosage of penicillin required may be sufficient to delay or abolish completely the appearance of the early signs of syphilis without checking its further progress. Treatment for gonorrhea may, therefore, mask developing signs and symptoms of syphilis, leaving the patient with a false sense of security —an unwitting victim of the spirochete.

There are no data from which it may be learned how often dual infections of gonorrhea and syphilis are acquired from one or more exposures within a short time, but as an important finding in the control of syphilis it has been noted that, over a period of one year, 9 per cent of the total admissions to the rapid treatment centres in the U.S.A. consisted of patients infected with both syphilis and gonorrhea. It must, therefore, be stressed that when any case of gonorrhea is treated, there should be a high index of suspicion that syphilis too may be present. This can only be detected by careful physical examination and blood testing.

Summary

In concluding this review one may state, in summary, from the information available it would apppear that the use of penicillin as an effective therapeutic agent for gonorrhea seems well established, and there is general agreement that with the commercial penicillin, as now produced, satisfactory results in the management of gonorrhea may be expected with a total dosage of 200,000 Oxford units or more. The major consideration remaining at the moment concerns the best schedule for administering the drug. Ideally, this would require a minimum of time plus a minimum of special equipment without any sacrifice of therapeutic efficiency. Ideally, too, the most desirable schedule would be one administered on an ambulatory out-patient basis and would combine safety, convenience, and the least possible discomfort for the patient. The achievement of these levels of near perfection in gonorrhea treatment may well be realized in the immediate future.

Better keep yourself clean and bright; you are the window through which you see the world.

With UNRRA in Germany

LYLE M. CREELMAN

LONG before VE-Day (May 8, 1945), which marked the end of the war in Europe, it was recognized that there were many problems of peace which must be dealt with on an international basis, and preferably by an international organization.

The most urgent of these was the task of caring for the millions of people of many nationalities who had been displaced from their homes by actual war; had fled before the enemy; had been offered the alternative of compulsory work in Germany or starvation; had been the victims of political or religious pressure; or had been part of the huge deliberate transfer of populations that, particularly in Poland and the Baltic States, had been carried out for political reasons. For all these people there was the problem of immediate relief, necessary rehabilitation and, ultimately, repatriation. For some there was no possibility of repatriation, and to the problem of relief and rehabilitation had to be added the possibility of resettlement, temporary or permanent, in some hospitable land.

The United Nations Relief and Rehabilitation Administration—UNRRA, as it soon came to be called — was set up to undertake this gigantic task, and, immediately upon the unconditional surrender of Germany, it was called upon to provide as rapidly as possible spearhead teams, complete units, and later specialized services to aid the army. These were finally to be welded into a semi-independent, co-operative agency. The earliest members were in operation even before the fall of Germany, striving to do whatever could be done among the masses of refugees, displaced persons, and hordes of allied and enemy civilians who literally in millions crowded the roads of western Germany.

There has never been any accurate estimate of the total number of displaced persons at that time in this area, but figures of from six to eleven millions have been quoted, and undoubtedly the truth lies between these — nearer the upper than the lower figure. All had suffered much in mind and body. They had been uprooted from their homes, and did not know if they would ever live to return or, indeed, if there would be a free homeland to which they could return. Many were separated from their families and often ignorant of their fate or only too well aware of it. Most of them were wretchedly ill-clad, hungry and deprived of all sources of regular food.

It was into this massive and somewhat terrifying confusion of people and problems that I was asked by the UNRRA chief medical officer in the British Zone in Germany to accompany him as chief nurse (June 11, 1945). My immediate reaction, when asked to organize the nursing service of UNRRA for the displaced persons operation in the British Zone of Germany, was an eager desire to accept the job, and a great happiness at having some small part in this tremendous undertaking.

GETTING READY

The inevitable delays associated with the collection of the necessary office staff, equipment and, above all, transport; the many formalities that had to be dealt with in respect of passports, travel orders, and all the essential but irksome red-tape associated with visiting what was still an enemy country under immediate military guard, occupied a month. Finally, all was ready, and the chief medical officer, and I, a secretary, two drivers, and two new cars proceeded from London to Purfleet, boarded an Army LST and set out in convoy to cross the Channel—rendered dangerous just then by a heavy storm in the North Sea which had caused thousands of mines to

(*Continued on page 552*)

INSTITUTIONAL NURSING

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

The Orientation of Nurses

MARGARET M. STREET

A PROGRAM of ward instruction was initiated in the Ross Memorial Pavilion, Royal Victoria Hospital, at the beginning of January, 1946. The program was designed to include both students and general staff nurses.

The Ross Memorial Pavilion has a capacity of 120 private beds. The objective has been to have an all-graduate nursing staff in this building. However, due to the shortage of nurses, it has not been found possible to realize this entirely, and there are always several students on each floor. The floors are segregated, as far as possible. Both general staff and student nurses are on straight eight-hour duty with occasional broken periods of duty in the day-time. They work a six-day week. A ward aide or a nurse's aide on each floor attends to such duties as changing the drinking-water, flowers, dusting, cleaning granite-ware and beds on discharge of patients, running errands, etc. An information clerk on each floor answers the telephones, takes messages to doctors and patients, helps to make out the ward slips, and directs visitors. Thus, the nursing staff can devote most of their time to the actual bedside care of the patients. This factor is favorable to the development of a ward teaching program.

ESTABLISHING THE WARD INSTRUCTION PROGRAM

1. The ward instructor submitted to the superintendent of nurses and to the supervisor of nursing of the Pavilion a plan for the program. This was referred to the instructor in charge of the teaching department. Constructive suggestions received from these sources were incorporated into the plan, which was then ready to be introduced.

2. A meeting was called of the supervisory and head nurse staff of the Pavilion, at which the ward instructor presented the plan for the ward teaching program. The objectives, scope, and proposed methods were outlined, and a copy of the plan given to each head nurse for study and comment. A copy of the plan was given also to the night supervisor for her information.

3. A meeting was called of the general staff nurses of the Pavilion, at which the ward instructor was given an opportunity to explain the manner in which it was expected that a staff education program might be developed.

4. The ward instructor had an individual, informal conference with each of the head nurses regarding the points in nursing care and in ward routines which should be stressed by the instructor in her contacts with both students and general staff nurses.

5. A ward instruction office was established in a convenient location. The office was partially screened off and contained the following:

A desk with locked drawers; chairs of a

type to be stored easily when not in use; a blackboard and a small bookcase; a locked filing box to hold 5" x 8" cards; a small source box; a reference library consisting of text or reference books and a medical dictionary; a file of literature on trade drugs.

This office is well lighted and is a pleasant, quiet place in which to hold conferences.

Nature, Scope and Methods

The ward instructor carries the dual responsibility of teaching and of assisting with the supervision of the nursing care of patients by the general staff and the student nurses. In both of these respects, she may be considered as rendering assistance to the head nurses, whose primary functions these are, but whose time is so taken up by the many administrative duties that they are not always able to devote as much time as they would wish to detailed supervision and teaching.

The ward instructor is on duty from 7:30 to 4, Monday to Friday inclusive. She has every Saturday off, and alternate Sunday mornings. The mornings are spent either in orienting new nurses or in visiting patients with a view to supervision of nursing care. The afternoons are spent in conferences, planning of work, records, etc.

Before commencing her morning visits to patients, the instructor reads the night report and makes notations regarding the new patients on each floor, pre-operative patients, patients who are slated for tests that day, and seriously-ill patients. She notes also the census of patients on each floor, with special reference to the patient-nurse ratio. Between eight and nine o'clock, on mornings when there are no new nurses, the instructor visits each floor and makes notes regarding the patient-assignment of all students and general staff nurses. She checks the treatment sheets and order books and notes points which she should check. During this initial visit to the floors, the instructor may stop to observe, for example, the work of a student in preparing a patient for the operating-room or for the x-ray department, or the preparation of a room for the return of a patient from the operating-room. She then commences her visits, and observes the morning care which is being given. Corrections and suggestions of a minor nature are usually made directly to the nurses concerned (outside of the patients' rooms), but more serious matters pertaining to patient care, and all matters pertaining to ward administration are reported to the head nurse. It is necessary for the ward instructor to exercise judgment constantly as to which matters should be referred to the head nurse. In practice, few difficulties have arisen. Students may be given assistance in giving morning care to sick patients—e.g., a cardiac patient in an oxygen tent; or a treatment may be discussed and the preparation for it checked with the student. It has not seemed feasible, for the most part, actually to supervise the giving of a treatment in the private rooms, although this has been done to limited extent, when it seemed in the best interest of the student and of the patient to do so.

The student nurses' program has the following objectives:

1. To assist in the orientation of the student: (*a*) to the physical plant and equipment of the Pavilion; (*b*) to the ward routines, and to the care of the private ward patient.

2. To assist in developing an appreciation of the factors contributing to good basic nursing care, and of meticulous workmanship in carrying out this care.

3. To assist in strengthening an appreciation of the importance of skilful observation of the patient in order to anticipate his needs, and of keeping before her the "patient point of view."

4. To contribute to the extension of the student's clinical knowledge by encouraging her to carry on independent, directed study by individual or group conferences, and by day-by-day supervision and bedside demonstration or instruction.

Formal Student Program

1. *Orientation of new students:* (a) Before the student comes to the ward, the instructor procures from the Training School Office a record of her clinical experience. This information

is transcribed to a 5" x 8" card, which is to contain the record of the student's conferences and progress. The back of the card is ruled to serve as a record of the ward teaching and supervision. The card is then filed in the "active" section of the locked file.

(b) The instructor endeavors to find an opportunity to discuss with the head nurse the clinical background of the student, with special references to points in which she may be expected to need special instruction and supervision—e.g., the student may have had no previous experience in ear, nose and throat nursing, in which case she will have to be supervised closely if assigned to the care of these patients.

(c) On the morning of the student's arrival on the floor, the head nurse explains the treatment and nursing care of the group of patients assigned. Following this, the ward instructor takes charge of the new student, and first explains the routine of the ward—factors in pre-breakfast care, in morning care, duties of the student, of the nurse's aide or ward aide, and of the orderly and the maids. She then shows the student the location of the chief service facilities, and takes her into the room of one of the patients assigned to her care. Here, she is introduced to the patient, and the instructor shows her where the patient's equipment is kept. She then proceeds to prepare her patients for breakfast. Inasmuch as the necessary orientation has taken some time (10-15 minutes), the instructor may assist the student, on this first morning, with the pre-breakfast and the regular morning care. After this has been completed in detail, and treatments, if any, recorded, and after any other duties for which she was posted have been performed by the student, the instructor conducts her on a detailed tour of the floor. Following this, usually from 11:00-12:00, an orientation conference is held in the instructor's office. The ward routines are further explained, the basic factors in good nursing care are reviewed, and the essentials in planning the daily care of patients are stressed and illustrated. An attempt is made also to encourage the student to define the learning objectives which she has in coming to this Pavilion, and to point out to her the learning opportunities which she will be able to find here. The student is then conducted on a tour of some of the main departments — the nursing office, the clerical office, the porters' station, the supply room, the linen room, the x-ray, the physiotherapy and the fever therapy departments. The functions of these departments are outlined, the manner in which they are related to the nursing service, and the ways in which the individual nurse may facilitate the work of each, in the service of the patients, are discussed.

If, as frequently happens, several new students come to the building on the same day, and to different floors, the ward instructor must decide in advance, by a study of the clinical backgrounds, which student or students will probably be most in need of her assistance. She then acquaints the head nurses with her plan of procedure. The head nurses will plan to carry on such orientation as may be essential until the ward instructor is free. There may be three or four students at the initial conference.

The conference schedule (both for students and for graduates) is posted a week in advance, after the instructor has obtained the nurses' hours of duty for the week, as planned by the head nurses. A typed copy of the conference schedule is posted on each floor, with copies going to the superintendent of nurses, the teaching department, and the supervisor of nursing. All conferences are held in the hours on duty, usually just before or after the noon-hour. Not more than one student or one graduate at a time will be scheduled for conference from one floor.

(d) On the second day, the instructor supervises as closely as possible the work of the new student or students, giving such guidance as may be necessary. A conference, one-half to one hour in length, is held on the topics: admission of private patients; methods of cleaning and preparing

articles for the autoclave, etc.

(e) On the third day, a conference is held on the manner of carrying out protective technique in this building.

2. *Continuing program:* This consists of: (a) continued supervision of the student and instruction as necessary; (b) planned conferences, including progress discussions.

3. *Reports:* The head nurse and the ward instructor confer regarding the student's progress and final rating, and write a joint report on which is also included a record of the ward teaching. The instructor makes a brief report on the student's card which is then filed in the "inactive" portion of the file.

Graduate Nurses' Program

1. *Orientation of graduates from other schools of nursing—Objectives:*

To assist the new staff member to adjust quickly and easily to the hospital and to the ward, and thus to promote her happiness and efficiency.

Method: The instructor orients the new graduate in much the same way as the student except that she gives more detailed assistance to the new graduate. Her patient assignment is usually light on the first day, and the instructor conducts her on a tour of the ward, the building, and, if possible, the hospital. Conferences are held every day for the first week to introduce the graduate to the procedures of the hospital, methods of charting, protective technique, method of admitting and of discharging patients, etc. The daily work of the graduate is also followed and assistance given as required.

2. *General staff nurses' program — Objectives:*

(*a*) To promote better nursing service through securing greater standardization of nursing practice at a uniformly high level.

(*b*) To assist in the professional growth and development of the general staff nurse.

Method: One or two conferences, one-half hour in length, are scheduled each week, and attended by groups of two to four graduates. Topics discussed have included: new drugs and treatments; demonstration of new or unfamiliar apparatus; nursing service problems; routine procedures and techniques, etc. In addition, groups of staff nurses have visited the x-ray department and have attended clinics in the fever therapy department. Orientation conferences have been given routinely. This program is felt by the participants to be of value. However, it is still comparatively undeveloped, and we look forward to the time when it will become more vigorous, with the nurses themselves taking the lead in preparing material and leading discussions. Such individual activity would undoubtedly make the program of more real and lasting value to the individual.

3. *Special nurses:* At the request of the supervisor of nursing, the instructor posted notices offering to assist in the orientation of special nurses unfamiliar with this hospital, and to give or to secure such other information as might be required. Assistance has been given to nurses returning to active nursing after periods of inactivity. This aspect of the program could be developed greatly if the time permitted.

Subsidiary Workers' Program

Nurses' aides: The ward instructor has given a brief period of instruction to nurses' aides and assisted in the supervison of this group.

Ward aides: The instructor has assisted in the orientation and instruction of ward aides.

Maids: The instructor teaches and supervises the work of the maids in rooms where full isolation technique is necessary.

The ward instructor finds her work most interesting, stimulating, and satisfying. Valuable assistance, cooperation and encouragement from the superintendent of nurses, the supervisor of nursing and her assistant, the head nurse, and the teaching department, have made it possible for this program to become established and to develop. It is our hope that it may gain greater strength and effectiveness as time goes on.

PUBLIC HEALTH NURSING

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

Emploi du B.C.G.

GEORGINE BADEAUX

LA vaccination contre la tuberculose par l'injection, l'ingestion ou scarification du B.C.G., ou bacille Calmette et Guérin, semble bien avoir traversé victorieusement la phase expérimentale et critique, si on en juge par les articles, les enquêtes, l'attention du monde médical, et de sa presse de plusieurs pays. Vingt-cinq années de patientes recherches ont mis en lumière sa valeur comme préventif de la tuberculose: des statistiques nombreuses, recueillies dans différents pays, notamment en France, en Suède, au Danemark, en Norvège, donnent lourdement raison aux disciples de Pasteur, de Koch, Weill-Hallé, Turpin, Calmette et Guérin.

D'abord donné exclusivement aux nouveaux-nés et dès leurs premiers dix jours d'existence, voilà que le B.C.G. prouve de l'efficacité protectrice chez les adultes anergiques. En France, le Ministère de la Santé a fait des expériences affirmativement concluantes dans les écoles d'infirmières et d'assistantes sociales, de même en Norvège et, plus près de nous, en Saskatchewan. Les Etats-Unis s'y intéressent enfin et mettront bientôt sur pieds une vaste organisation expérimentale pour eux, en vaccinant 100,000 personnes dans les états du Sud, où la mortalité par tuberculose a un pourcentage élevé. (*Time*)

Il n'est pourtant pas éloigné le temps où les déclarations contradictoires, la confusion des faits, des opinions diverses émises avec autant d'aplomb, désarçonnaient l'observateur et le laissaient dans l'incertitude. Les infirmières hygiénistes, uniquement dévouées à la lutte anti-tuberculeuse, tel les infirmières du Service Social de l'Institut Bruchési, ne peuvent avoir oublié les impasses malheureuses traversées quand le médecin de famille ne secondait pas la prescription du B.C.G. à des nouveaux-nés. En plus de déplorer la perte de protection pour ces enfants de familles contaminées, quel déplaisir pour l'infirmière de ne pas pouvoir affirmer au directeur que 100 pour cent des enfants nés dans leurs foyers visités étaient immunisés!

On a donné une publicité profuse aux enquêtes, aux statistiques, aux déductions scientifiques décrites par des autorités médicales dans plusieurs revues, aussi cet article ne veut aucunement répéter la composition du vaccin, la technologie, l'obligation de la revaccination périodique, encore moins les inconvénients des alternances allergiques et anergiques. Il veut très simplement mettre à jour l'emploi du vaccin B.C.G. dans al lutte anti-tuberculeuse à Montréal de 1926 à nos jours.

DEBUTS DU B.C.G. A MONTREAL

C'est en 1921 que Calmette administra le premier vaccin à un être humain; en 1924, l'Institut Pasteur de Paris était prêt à faire la diffusion du vaccin en France, sur demande.

Les relations culturelles de notre université canadienne-française expliquent que dès 1926, donc, très près du début, le Département de Bactériologie de la Faculté de Médecine de l'Université de Montréal cultiva une source de vaccin apportée de l'Institut Pasteur de Paris par le Docteur Petit. Les étudiantes de l'Ecole des Infirmières Hygiénistes, alors appelée "Ecole d'Hygiène sociale appliquée," furent les pionnières de la vaccination par B.C.G. en Amérique. Cette même année on vaccina une centaine de bébés, et sous les auspices du Conseil National de Recherches, le Service du B.C.G. de l'Université de Montréal entreprit le travail statistique. Minutieusement, tous les détails médicaux et sociaux du vacciné et de son entourage furent notés: la même méthode est en cours aujourd'hui. Environ 400 familles sont ainsi surveillées, depuis cette époque, au point de vue de l'incidence de contagion tuberculeuse, et surtout pour faire l'éducation et obtenir l'examen pulmonaire périodique des vaccinés et des non-vaccinés, les témoins. A date, les résultats sont favorables à la vaccination dans la proportion d'un décès chez les vaccinés contre cinq chez les non-vaccinés.

Les étudiantes de l'Ecole des Infirmières Hygiénistes sont heureuses d'être les ouvrières de la première heure, de même que les infirmières hygiénistes canadiennes-françaises qui font la lutte à la tuberculose, à Montréal. Les infirmières de l'Assistance Maternelle ont aussi été propagandistes de cette vaccination, de même que les hôpitaux canadiens-français sur prescription médicale et autorisation des parents.

A l'Institut Bruchési, depuis 1926, les infirmières sociales favorisent l'immunisation. Dans leurs nombreuses familles surveillées, durant l'année 1945, 141 enfants sont nés, 115 reçurent le B.C.G., soit 81.5 pour cent.

La Clinique du B.C.G.

Toute infirmière sociale en tuberculose reconnaît comme premier devoir l'éducation du malade et de sa famille. Cette éducation est particulièrement importante quand elle protège la vie du nouveau-né. L'efficacité du vaccin B.C.G. est attachée à de nombreux facteurs: l'intégrité du vaccin, la technique d'administration, puis et surtout, l'isolement du vacciné jusqu'à l'établissement évident de son allergie. Avant l'année 1934, l'éducation que l'infirmière sociale donnait aux mères ou aux gardiennes de l'enfant était la seule garantie de cet isolement. Si donc les statistiques couvrant la période 1926 à 1939 sont à l'avantage du vaccin et que l'isolement ou la non-contamination familiale du nouveau-né est essentielle durant au moins deux mois, de quel poids cette éducation pèse-t-elle dans la mesure du succès!

Depuis 1934, une clinique d'isolement est ouverte aux nouveaux-nés; au numéro 2427, rue Létourneux, un immeuble spacieux est aménagé pour recevoir 80 enfants. La puériculture y est souveraine; des spécialistes pédiâtres régissent l'administration et une école de puériculture pour jeunes filles. Quand les parents consentent à la séparation, et c'est un devoir de les faire consentir dans l'intérêt de l'enfant, le nouveau-né est sorti du milieu contaminé dès les premières heures de son existence pour revenir chez lui dans un état allergique, c'est-à-dire à trois ou six mois.

Les statistiques de notre province en fait de taux de mortalité par tuberculose plongent tout québecquois dans une sombre confusion; cependant, réjouissons-nou d'avoir eu foi dans la science de Calmette et Guérin, une foi qui a déjà sa récompense dans le salut de nombreuses vies d'enfants et une foi qui a dressé la clinique du B.C.G., seule organisation du genre en Amérique.

Avec l'oeuvre Grancher, qui est le placement familial à la campagne des enfants de milieu tuberculeux de 1 à 12 ans, la Clinique du B.C.G. apporte souvent la solution aux problèmes familiaux et sociaux, malheureusement, les nécessiteux n'en bénéficient pas tous parce qu'on rencontre des objections d'ordre senti-

mental et financier plus ou moins difficiles à vaincre.

Quand la mère est tuberculeuse, la séparation s'impose et le placement du nouveau-né à la clinique offre une heureuse opportunité, mais que le père, ou le frère, ou la soeur soient les bacillifères du foyer, les parents ripostent sensément: "Placez le malade, c'est lui qui nécessite des soins que nous ne pouvons lui donner." L'isolement ou la non-contamination de l'enfant demeure le fruit de l'éducation, de l'enseignement de l'hygiène, et aussi d'auxiliaires éloignés, aides importants qui sont l'amélioration des conditions de logement, la disparition des taudis, et l'augmentation du salaire familial.

Assainissements des Foyers

Dans l'armement anti-tuberculeux, la vaccination par B.C.G. est au chapitre de la prophylaxie: "Pour sauver le ver à soie," a dit Pasteur, "sauvons le cocon." Elle n'est pas cependant une arme de combat comparable au lit de sanatorium. Nul ne contredira que la tuberculose se combat par le lit au sanatorium qui fait l'assainissement des foyers, de la population par la guérison et la réhabilitation des malades.

Sans chercher dans les statistiques et expériences étrangères à notre pays, voyons tout près de nous la province d'Ontario qui, tout en ignorant la vaccination par B.C.G., a baissé à 26 par 100,000 de population son taux de mortalité, mais sachons qu'elle dispose de 3.3 lits par décès, alors que nous, dans le Québec, n'avons que 1.5.

C'est de la simple logique de penser que la vaccination par le B.C.G. donnera son maximum de protection (pas 100 pour cent, nul vaccin ne le donne) et sans exiger un démembrement de l'unité familiale quand les foyers seront assainis, quand cette augmentation de résistance à l'infection tuberculeuse que le vaccin donne aura à parer aux contaminations aléatoires dans les relations interhumaines, sociales ou professionnelles.

In view of the present widespread interest in B.C.G. vaccination, it is gratifying to recall that the students in the school for graduate nurses of the "Université de Montréal" were the pioneers in America in this movement. In 1926, five years after Calmette used his vaccine for the first time on a human being, one hundred babies were vaccinated in the school's health centre, and since that time records have been kept which show very encouraging results. In 1934, an isolation clinic for newborn babies from tuberculous families was opened in Montreal. Here the babies are vaccinated and they spend from three to six months in the clinic, depending on the need. This clinic, in combination with the Grancher System, which safeguards older children who are contacts, would seem to offer a solution, in part at least, to the problem of prevention of tuberculosis in the Province of Quebec.

The Canadian Citizenship Act Analyzed

The Act of the Dominion Parliament "respecting citizenship, nationality, naturalization, and Status of Aliens" was officially proclaimed on January 1, 1947. The press across the Dominion has given prominence to the ceremonies attending the granting of the first Certificates of Citizenship, and it is interesting to note that one of the terms of this Act gives the Courts authority to continue to make the granting of such certificates a suitably dignified and impressive ceremony. Those of us who have ourselves become naturalized know only too well the effect of the off-hand, almost totally disinterested procedure that formerly accompanied this exceedingly important step, and it is to be hoped that the Courts

will avail themselves of the opportunity they now have to make the matter of becoming a citizen of Canada something to be remembered with pride.

The Act itself, for such an important piece of legislation, is not long and has been conveniently set up in nine separate parts, some of which are briefly analyzed below.

In a commentary on the Act and its terms appearing in the "Municipal Review of Canada," Bernard Ross, K.C., points out that a "citizen" is in a sense superior to a "subject." This distinction appears in the Act itself (Part IV, Sec. 25 and 26) when it is stated that "a Canadian citizen is a British subject," and . . . "is entitled to all the rights, powers and privileges, as well as the obligations, duties and liabilites of . . . a citizen." These privileges and obligations are not set out in detail, but in placing them in juxtaposition, the essence of the meaning of citizenship is strongly implied, which gives to the Act a moral fibre that is inspiring.

Part I, perhaps the most improtant part of the Act, follows the usual definition of terms, and sets out clearly the right of Canadians to declare themselves as Canadian citizens. Legal phraseology usually robs the content of any Act of any literary value — by which we mean the spiritual and emotional overtones that the written word can be made to convey — but Section 3, which deals with these new-found rights, is an exception surely. It reads like this: . . . "Where a person is required to state or declare his national status, any person who is a Canadian citizen under this Act may state or declare himself to be a Canadian citizen, and his statement or declaration to that effect will be a good and sufficient compliance with such requirement." Bravo!

Now, under the Act, who is a Canadian citizen? In the case of natural-born Canadians, here it is:
(Section 4)

The following persons, born before the coming into force of this Act, are natural-born Canadian citizens:

(*a*) Any person born in Canada or on a Canadian ship, who has not become an alien at the time of the coming into force of this Act, and

(*b*) Any person born outside of Canada, . . . whose father, or in the case of a person born out of wedlock, whose mother

1. Was born in Canada, or on a Canadian ship, and had not become an alien at the time of that person's birth, or

2. Was, at the time of the person's birth, a British subject who had Canadian domicile, (5 years residence), if, at the time of the coming into force of this Act, that person had not become an alien, and has either been lawfully admitted to Canada for permanent residence, or is a minor.

Persons born in Canada after the commencement of this Act—of Canadian parentage — are automatically citizens, but if they are not of Canadian parentage, they may, after reaching twenty-one years of age, make a declaration thay they wish, or do not wish to assume Canadian nationality. On the other hand, a child born outside of Canada of Canadian parents must be registered with the Canadian Consulate in that country, or with the Secretary of State, if their parents wish the child to have Canadian citizenship upon reaching his majority.

Every foundling, first found as a deserted infant in Canada, shall be deemed to have been born in Canada until the contrary is proved. And where a child is born after the death of his father the child is deemed to have been born immediately before the death of his father.

Part II deals with those who are not natural-born Canadians. The Minister (Secretary of State) has the authority to grant a Certificate of Canadian Citizenship to a person who:

(*a*) Was granted, or his name was included in, a certificate of naturalization, or

(*b*) Was a British subject who had Canadian domicile, or

(*c*) In the case of a woman, if she

1. Before the commencement of this Act was married to a man who is a natural-born Canadian citizen, or

2. At the commencement of this Act is a British subject, lawfully admitted to Canada for permanent residence.

For those who are not British subjects and have not become naturalized, the method of acquiring Canadian citizenship is as follows:

A declaration of intention to become a Canadian citizen must be filed with the Clerk of a Court (Superior, Circuit, County or District Court) not less than one year and not more than five years prior to the date of his application. When making application it must be proved to the Court's satisfaction that he has been lawfully admitted to Canada for permanent residence, has resided continuously in Canada for a period of one year immediately preceding the date of application (except for members of the Armed Forces who may have been absent on duty); that he is of good character, has an adequate knowledge of either the English or French language, (or if he hasn't such knowledge that he has resided continuously in Canada for more than twenty years); that he has an adequate knowledge of the responsibilities and privileges of Canadian citizenship; and that he intends, if his application is granted, either to reside permanently in Canada, or to enter or continue in the public service of Canada or of a Province.

British subjects may obtain a certificate on application, on payment of $1.00 (not $5.00 as originally announced in the press), members of the Armed Forces obtaining them free of charge. The Minister has discretion to grant a certificate where doubt exists, and has authority to refer any application back to the Court for a hearing.

Part III deals with the loss of Canadian citizenship should a Canadian living outside of Canada, and not being under a "disability" (i.e., is not a "minor, a lunatic or an idiot"), by any voluntary or formal act other than marriage acquire the nationality of another country, he ceases to be a Canadian citizen. A citizen of Canada serving in the Armed Forces of any other country when it is at war with Canada loses his right to citizenship. Where the responsible parent ceases to be a Canadian citizen, the child thereupon ceases to be a Canadian citizen, but if the child chooses, after becoming 21 years of age, he may make a declaration and thereupon become a Canadian citizen. You do not lose your Canadian citizenship if you are a Canadian woman and marry an alien.

Section 19 authorizes the Governor-General-in-Council to revoke for adequate cause the citizenship acquired by anyone not a natural-born Canadian, in which case every latitude for adequate defence is provided.

Part IV, dealing with the Status of a Canadian citizen, was reviewed in the third paragraph of this summary.

Part V deals with the Status of Aliens, who may own property, but who may not hold public office nor have the franchise, may not own a Canadian ship, nor have any of the rights or privileges of a citizen. Section 30 within this part provides that aliens be triable at law.

Part VI deals with the procedure and evidence required in acquiring a certificate, and in taking the Oath of Allegiance.

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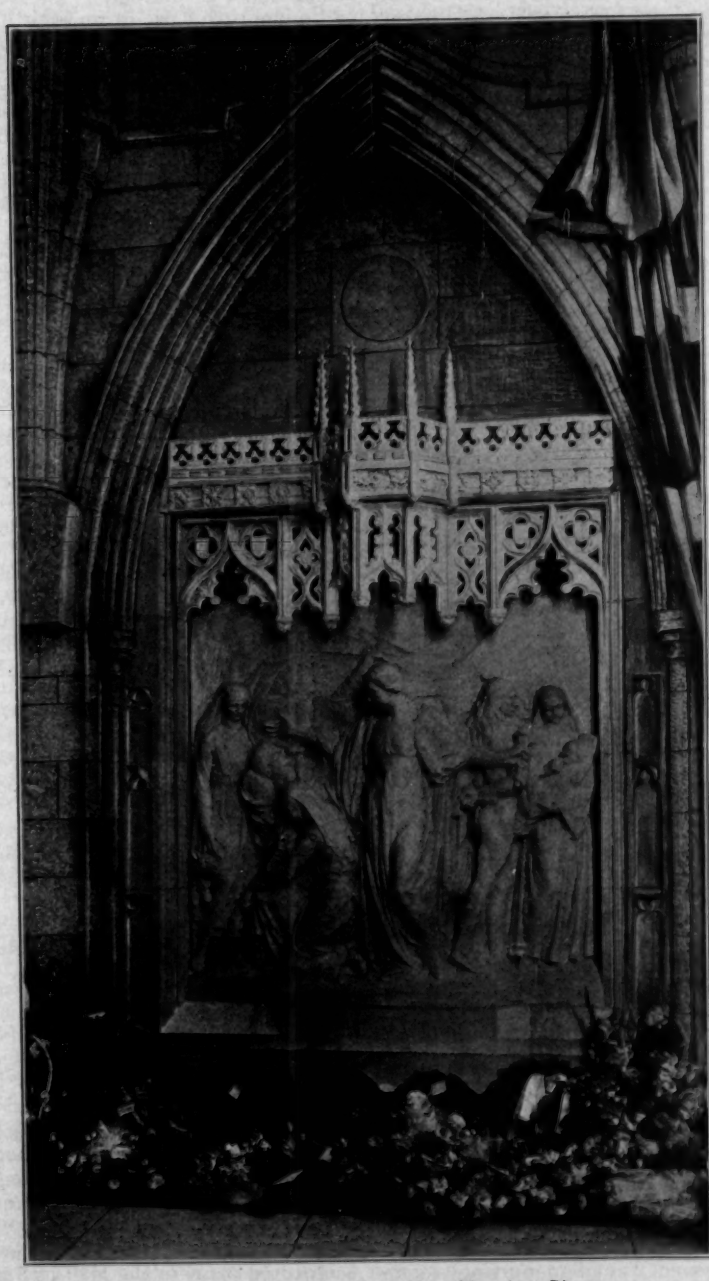
The Memorial at Ottawa

During the thirteenth general meeting of the Canadian Nurses' Association held in Ottawa the third week in August, 1926, an unusually impressive ceremony took place — the unveiling of the Memorial to the forty-seven Canadian nursing sisters who had given their lives during World War I. A full account of this ceremony was published in the October, 1926, issue of the *The Canadian Nurse*. Many of the nurses of Canada have never had the opportunity to visit Ottawa and view the beautiful sculptured panel in the Hall of Fame. For these and to refresh the memories



The Memorial to the Canadian Nursing Sisters

of the older nurses who were instrumental in raising the funds twenty-five years ago to erect this Memorial, we are reproducing the original picture taken after the unveiling. The inscription reads as follows:

Erected by the nurses of Canada in remembrance of their sisters who gave their lives in the Great War, nineteen fourteen-eighteen, and to perpetuate a noble tradition in the relations of the old world and the new.

Led by the spirit of humanity across the seas woman by her tender ministrations to those in need has given to the world the example of an heroic service embracing three centuries of Canadian history.

Miss Jean E. Browne, as president of the Canadian Nurses' Association, presented the Memorial to the people of Canada from the nurses of Canada. In making the presentation, Miss Browne said:

In order to explain the Memorial which has been erected in their honor, it is necessary to sketch briefly the background of the history of nursing in Canada. Nursing was introduced into Canada almost three hundred years ago by two devoted French women — Mademoiselle Mance and Madame de la Peltrie. These ladies left the civilization of the Old World to come to the little colony that was then called New France, and they established hospitals where the cities of Quebec and Montreal stand today. Nursing at that time was carried on entirely by members of religious orders in the face of hardships and perils which it is difficult even to imagine today.

From a scientific point of view, the nursing of today has very little in common with the nursing of three hundred years ago, but we believe that the tradition of courage and loyalty and sacrifice has come down to the present generation of Canadian nurses from those brave early pioneers. I think you will agree with me that the quiet everyday tasks of the nurse require courage and devotion beyond that of the ordinary individual.

When the call of the country came in 1914, large numbers of Canadian nurses volunteered for service overseas and, until the end of the war, there was always a long waiting list ready to be called. The Canadian Nurses' Association is proud of the record of the Canadian Army Nursing Sisters. Whether facing the perils of the sea on transport duty, or enduring the heat and extreme discomforts of Gallipoli, in the dangers of the clearing stations near the fighting line, or in the huge base hospitals in France, in the exhausting duties of the base hospitals in England, or in the more prosaic work of the base hospitals in Canada, we believe that the Canadian Army Nursing Sisters acquitted themselves with honor at all times. Of some of them the great sacrifice was demanded, and they were faithful unto death. These the nurses of Canada revere.

At the close of the war, it was felt in the Canadian Nurses' Association that steps should be taken to give this reverence some tangible form that might be left for posterity, so a plan was formulated to raise a fund to erect a Memorial. I think I may say to you that this Memorial has been raised through the independent efforts of some ten thousand organized nurses in Canada, and we believe that this sculptured panel, which has been placed in the Hall of Fame, will typify to some degree at least, through the fine beauty of line and the purity of its marble, the nobility of those nursing sisters who were valiant and unshaken even in the face of death.

We want the people of Canada, both those of the present day and those of the great future, to share with us our exalted pride in our glorious dead.

Preview

The problem of the care of the chronically ill and aged is one which has become more and more involved during recent years. Crowded living accommodation in the homes frequently necessitates some form of institutional care for this group, who range from those who are ambulatory and able to manage with a negligible amount of nursing care, to those who are bedfast and helpless. Next month we will focus our attention on this problem in a series of articles headed up by **Sarah B. Gelbach** who sketches in the outline of the needs of this group. Three nurses on the staff of the Runnymede Hospital, Toronto — **Edith Rowe, Jane LeWarne,** and **Jessie Wilson** — describe the details of nursing care. **Muriel F. Driver** writes of the value of carefully guided occupational therapy for these people. Rounding out this series, we present **Anne B. Connor's** consideration of the educational value to the student nurse of training in this care.

Notes from National Office

Executive Committee Meeting

A meeting of the Executive Committee of the Canadian Nurses' Association was held in Montreal on April 28-30, 1947. Those present included: Miss R. Chittick, president; Misses E. Cryderman, E. Mallory, M. Myers, Pettigrew, Macleod, Kay, McArthur, Connor, Emerson, Burton, Grady, Fidler, Flanagan, Ellis, Upton, Walker, Wright, Law, Watson, Mmes D. Harrison and L. MacDonald, Rev. Sisters D. Lefebvre, Clermont, Columkille, Mary Beatrice, Mary Kathleen, St. Gertrude, Mary Irène, Valérie de la Sagesse, Misses Hall, Cooke, and Kerr.

All provincial associations were represented at this meeting.

Highlights of Reports

General Secretary's report: The secretarial staff at National Office obtained data concerning requirements for registration from each provincial registrar and prepared a report for the General Council of Nurses for England, Scotland and Wales, the Royal College of Nursing, and the National Council of Nurses of Great Britain.

A questionnaire to determine the interests of nurses and to receive suggestions for possible activities was prepared by the secretarial staff at National Office and sent to the provincial associations for distribution.

Financial assistance to nurses of the Netherlands to the amount of $1,130.40 has been provided by the provincial associations to bring two delegates from the Netherlands to attend the I.C.N. Congress. Our objective was $1,500.

The Deputy Minister of National Health has advised National Office that the request for the sum of $4,375, in each of the fiscal years 1946-47 and 1947-48 for administration of the school of nursing grant, has been recommended to the Minister of National Health and Welfare for inclusion in the estimates for the coming year. He has every reason to believe that this money will be granted.

Excerpts from the press clippings are being prepared each month and sent to provincial nurses' associations by National Office.

A total of five hundred replies to letters of inquiry and twenty thousand pieces of publicity have been sent out in response to individual and provincial requests for information about nursing.

Questionnaires: (1) In an endeavor to determine the number of high school students who are interested in becoming nurses, questionnaires were sent to the nine provincial departments of education. (2) A spot study of twenty-six representative hospitals, to determine the nurse-patient ratio, was prepared. From the information obtained, we were able to determine the percentage of various types of nursing service personnel in hospitals. Post-graduate course outlines, now being offered by university hospitals and public health organizations in Canada, are being revised and brought up-to-date.

Six parcels of used shoes and stockings have been sent via mail to Greek nurses, a total of forty-eight pairs of shoes and several pairs of stockings. Since this report was prepared we have shipped through the Greek War Relief twelve boxes of used shoes. Instructions have been issued to deliver these boxes to the State School for Nurses, St. Lampsakou, F. 7, Athens, Greece.

Seventeen copies of used Proposed Curriculum and Supplement have been sent to the devastated countries

of Europe, to aid instructors in schools of nursing.

Notes from National Office: The question has frequently been raised regarding the release to *The Canadian Nurse*, under "Notes from National Office," of information concerning current developments in nursing. The policy has always been to delay publishing any such information until cleared through the Executive Committee. Consequently, there is an accumulation of material for publication in the issues immediately following executive and general meetings with an intervening period when little information is available. The complaint on the part of nurses in general is that the information when released is no longer news. Consideration was given to a revision of this system and it was decided that the policy of releasing news concerning developments in nursing earlier, as suggested, be endorsed.

Treasurer's Report

The general secretary was appointed general secretary-treasurer.

The membership fees paid in 1946 were based on the membership at December 31, 1945, whereas under the revised by-laws the fees which are payable quarterly in 1947 will be based on the membership for the respective periods in that year. It was necessary, therefore, to adjust the fees for 1946 to the basis of the 1946 membership. For example, if there was an increase in the membership of the provincial association at December 31, 1946, over that of December 31, 1945, an adjustment in membership fees was necessary at the rate of $1.00 per member for that difference. A refund was made by the Canadian Nurses' Association at the same rate for any decrease in membership in the above-mentioned period. Such adjustments have been made on the basis of the accompanying comparative statement of membership in the various provinces.

The first instalment of the 1947 membership fees is payable April 1, based on membership at March 31, 1947.

Committee on Educational Policy

Subsidiary nursing group: This committee sat as a whole and considered the correspondence, and discussed the question of name, uniform, and insignia for such trained workers. No definite policy was decided upon.

Demonstration School Administration Committee: At the sub-committee meeting held in January, 1947, Miss Nettie D. Fidler, who had been recommended by the Administration Committee for the position of director of nursing of the Demonstration School, was asked to investigate the hospitals considered suitable for this school.

Miss Fidler presented reports of her visits to the various hospitals. It was realized that before final arrangements could be made with any board it would be necessary to have the assurance of full registration privileges for the graduates of such a Demonstration School in the province concerned.

In Quebec, the new Act of 1946 necessitates a three-year course of nursing and any school with less could not be certified in the province. The waiver clause, however, would allow the registration in Quebec of such students, if they were registered and in good standing in another province.

Schools of nursing in Ontario are at present under consideration but no definite decision has yet been made.

Miss Fidler's appointment as director of the Demonstration School was confirmed.

Committee on Labor Relations

The work of the committee is concerned with.

1. Methods of collective bargaining for nurses.
2. The relationship of nurses to trade unions.
3. Interest in Dominion and Provincial Labor Department Regulations that affect or may affect nurses.

Collective bargaining for nurses: An investigation proved that it was not legally possible for the provincial

Province	*Membership 1946*	*Increase in membership over 1945*	*Decrease in membership over 1945*
Alberta	1,936	113	—
British Columbia	3,925	349	—
Manitoba	1,788	—	6
New Brunswick	896	47	—
Nova Scotia	1,698	153	—
Ontario	6,004	—	1,178
P. E. Island	159	14	—
Quebec	5,701	443	—
Saskatchewan	1,620	107	—
Total	23,727	1,226	1,184

Net increase in 1946 membership over 1945, 42.

associations in the majority of provinces to act as bargaining agents. The committee felt that some other method of collective bargaining for nurses should be devised by which this responsibility could be kept within the professional group. According to information available, at least two of the provinces to date have had representatives of the provincial association certified as bargaining agents for groups of nurses.

Relationship of nurses to trade unions: As a result of the study of the relationship of nurses to trade unions, the committee again expressed the opinion that affiliation with a union could not offer to nurses the understanding and strength that they have in their own profession, and that the organization of trade unions, with the use of a strike as a legal weapon of collective bargaining, is not applicable to nursing service.

There are several instances already commented upon in committee reports of nurses becoming affiliated with trade unions through joining employees' associations. In some of these cases, we feel the nurses would have been better advised to have taken direction from their provincial associations in organizing along the lines suggested for their profession, while others, we realize, joined because it was the only way available to them for finding solutions to their problems.

The following excerpt from a letter refers to a situation bearing some similarity to the Willesden incident but occurring in our own country:

The local problem concerning public health nurses in the employ of the city of Toronto is still giving cause for concern. In December, a memorandum was presented to the mayor urging that the claims of professional groups be recognized and that the compulsory union membership order be amended to exclude them. Yesterday, our legal counsel, our president, and the convener of the Advisory Committee to Local Nursing Groups, along with representatives from the medical, dental, and professional engineer groups, appeared before the City Council to

ask specifically that, when the union shop agreement with the Municipal Employees' Union is renewed in April, these groups be excepted from the terms of the agreement and that no compulsion be exercised either for union membership or for contributions to the union under the R and Formula.

In Section 10 of the Draft Bill for the Industrial Relations and Disputes Investigations Act, 1947, which it is proposed will be introduced to Parliament by the Federal Department of Labor to replace PC-1003, brought in as a wartime measure to give the Dominion Government more jurisdiction in provincial labor matters, it is provided that if the majority of a group of employees belonging to a craft or profession are organized into a trade union, such union may apply to be certified as a bargaining agent for that group of employees. Bargaining agents for nurses appointed in that way might, therefore, be outside the nursing associations. After consultation with the legal adviser the following motion was, therefore, passed:

WHEREAS, The Canadian Nurses' Association is of the opinion that only members of the nursing profession are adequately informed to bargain collectively on behalf of that profession;

AND WHEREAS, Section 10 of the first draft of the Bill for the Industrial Relations and Disputes Investigation Act, 1947, proposed by the Federal Department of Labor, does not make specific provision for such representation; therefore be it

Resolved, That the Canadian Nurses' Association request the Department of Labor of Canada that Section 10 of the proposed Act be amended to read as follows:

"10. (1) Where the majority of a group of employees of an employer belonging to a craft or profession distinguishable from the employees as a whole so desire, such group may form a unit for collective bargaining and may apply to the Board to have members of their craft or profession certified as bargaining representatives for such unit.

"(2) The employees in such a unit shall if they so desire be excluded from any other unit for collective bargaining and shall not be taken into account as members of any such unit for any purposes of this Act."

Coverage given nurses by the Workmen's Compensation Act:

ALBERTA:

All nurses employed in provincial government hospitals are protected against accident. Several of the city and municipal hospitals have similar coverage but not all of them. There is no coverage for tuberculosis.

BRITISH COLUMBIA:

All nurses in the employ of the following are protected as far as accidents are concerned: government-aided hospitals; provincial government hospitals; private hospitals; municipalities; provincial government; industries which are covered by the Act.

All nurses employed by government-aided or provincial government hospitals are covered for tuberculosis if found after six months' employment.

NEW BRUNSWICK:

All nurses in the employ of all hospitals, regardless of type, are protected against accident.

Public health nurses in municipalities are not covered.

NOVA SCOTIA:

No employees of hospitals are covered for compensation under the Act.

SASKATCHEWAN:

The following nurses are covered:

All nurses in hospitals, nursing homes, rest homes, homes for the care of the aged, sick or indigent, and the Children's Aid Society. This coverage includes all student nurses.

All nurses employed by the Government of Saskatchewan and by the municipal authorities in Regina, Moose Jaw, and Saskatoon.

All nurses employed in industries covered by the Workmen's Compensation Act.

Coverage under the Workmen's Compensation Act in this province does not include tuberculosis. It has been discussed but the decision was made not to include it.

Unemployment insurance: According to reports received from some of the provinces, unemployment insurance is still giving rise to dissatisfaction among the nurses affected by it.

Loan and Bursary Fund

The Canadian Nurses' Association

wishes to announce that funds are available for graduate nurses to obtain a loan up to $500 to enable them to take post-graduate work. The demand for nurses with special preparation, both in hospitals and in the public health field, is far in excess of the supply, and an adequate number of well-qualified supervisors, teachers, and administrators in both fields is of paramount importance. These loans are granted to graduate nurses so that they may fit themselves for positions of responsibility and leadership in the nursing profession.

Registered nurses who are in good standing as members of a provincial registered nurses' association are eligible to apply.

The maximum period for any loan is five years. The loan is interest free for a period of three years, and if not repaid in this time interest is charged at the rate of 5 per cent commencing from the date of the third anniversary of the loan and continuing thereafter until payment in full is made.

Repayment of the loan must commence as soon as possible after the completion of the post-graduate course. If the recipient ceases to practise as a nurse, the balance then remaining due must be paid immediately. Any nurse who obtains a loan must agree to serve as a nurse in Canada for a period of one year.

Application forms may be obtained from National Office and will be sent upon request.

Bursaries are also obtainable for outstanding nurses who wish to do advanced work on a high level. Exceptionally well-qualified graduate nurses who wish to take more advanced work may obtain application forms from National Office.

Resolutions

1. *Resolved*, That the present procedure in regard to the handling of securities be followed in all routine matters. In the event of an urgent situation arising, the general secretary-treasurer, with the approval of the president, be given power to act. In the event of the president being unable to act, the approval must be secured of the next-ranking vice-president available. In the event that the general secretary-treasurer is not available to handle such an urgent situation the attorney appointed by the general secretary-treasurer shall immediately confer with the president who shall give permission to act after conference or meeting with the Sub-Executive Committee.

2. WHEREAS, The question has arisen of contributed articles published in *The Canadian Nurse* contravening fundamental philosophies of any recognized group within the association; therefore be it

Resolved, That the Editorial Board be asked to define their policy in regard to this question.

3. *Resolved*, That as a number of the readers of *The Canadian Nurse* have written to the office of the *Journal* objecting to certain statements in the article "Guilt and Anxiety as Social Controls" published in the February, 1947, issue, the Executive Committee of the Canadian Nurses' Association request *The Canadian Nurse* to publish the statement that the views expressed in the above-mentioned article are the views of the writer, that they have not been officially endorsed by this association, and that they were presented as the author's own interpretation.

4. *Resolved*, That the thanks and appreciation of this executive be extended to Mr. W. B. Scott, legal adviser, for his help and advice, and to the management and staff of the Ritz Carlton Hotel for their courteous and efficient service.

Notes du Secrétariat de l'A.I.C.

ASSEMBLÉE DU COMITÉ EXÉCUTIF

Une assemblée du Comité Exécutif de l'A.I.C. eut lieu à Montréal du 28 au 30 avril.

Toutes les associations provinciales étaient représentées à cette assemblée par les personnes suivantes: Mlle R. Chittick, présidente; Mlles E. Cryderman, E. Mallory,

McArthur, Connor, Emerson, Burton, Myers, Pettigrew, Macleod, Kay, Grady, Fidler, Flanagan, Ellis, Upton, Walker, Wright, Law, Watson, Mmes Harrison et L. MacDonald, Rév. Soeurs D. Lefebvre, Clermont, Columkille, Mary Beatrice, Mary Kathleen, Ste-Gertrude, Mary Irène, Valérie de la Sagesse, Mlles Hall, Cooke, et Kerr.

Le secrétariat du Bureau National a obtenu des renseignements de chacune des registraires des provinces concernant les conditions requises pour l'enregistrement provincial et a préparé un rapport pour le Conseil Général des Infirmières d'Angleterre, d'Ecosse, et du pays de Galles, le Collège Royal des Infirmières, et pour le Conseil National des Infirmières de Grande-Bretagne.

Un questionnaire fut préparé par le secrétariat et envoyé aux associations provinciales pour distribution afin de connaître ce qui intéresse les infirmières et recevoir des suggestions dans le but d'y répondre, si possible.

L'aide financière aux infirmières des Pays-Bas a été de $1,130.40. Cette somme reçue des associations provinciales a permis de faire venir deux déléguées au congrès international.

Le Sous-Ministre de la Santé a communiqué au Bureau National que la demande de $4,375, pour l'administration des écoles d'infirmières durant les années 1946-47 et 1947-48, a été présentée au Ministre de la Santé et du Bien-Etre Social pour y être inscrite au budget de l'année.

Nous avons raison de croire que cette somme nous sera accordée.

Des extraits de coupures de presse concernant la profession ont été envoyés par le secrétariat aux associations provinciales.

Le secrétariat a répondu à 500 demandes de renseignements et a envoyé 20,000 articles de publicité concernant la profession.

Questionnaires: (1) Dans un effort pour déterminer le nombre d'étudiantes des écoles supérieures, intéressées à devenir infirmières, des questionnaires furent envoyés aux neuf départements de l'instruction publique. (2) Un autre questionnaire fut envoyé à un groupe de vingt-six représentantes d'hôpitaux pour déterminer la proportion existante entre les infirmières et les patients; celà nous a permis de déterminer le pourcentage existant dans diverses catégories du nursing.

Les programmes des cours post-scolaires, offerts par les hôpitaux universitaires et les services de santé au Canada, ont été revisés et mis à la page.

Six colis, contenant des chaussures usagées, ont été envoyés à l'Ecole d'Infirmières de Grèce, St-Lampsakou, F. 7, Athènes, Grèce. Dix-sept exemplaires usagés du Programme d'Etude et du Supplément, à l'usage des écoles du Canada, ont été envoyés dans les pays dévastés d'Europe afin d'aider les institutrices dans les écoles d'infirmières.

Les contributions payées en 1946 le furent d'après le nombre de membres inscrits le 31 décembre 1945; maintenant, d'après nos nouveaux règlements, les contributions seront payables à chaque trimestre et d'après le nombre de membres inscrits à cette période de l'année. (Voir dans version anglaise le tableau donnant le nombre des membres pour chaque province, etc.)

COMITÉ DE LA POLITIQUE EDUCATIONNELLE

Le Comité de la Politique Educationnelle a siégé dans le but de discuter de la question *des aides ou auxiliaires.* La discussion a porté sur le nom, l'uniforme, et l'insigne pour ce groupe. Aucune ligne de conduite définitive n'a été adoptée.

Le Comité Administratif de l'Ecole de Démonstration: A une réunion du sous-comité tenue en janvier 1947, Mlle N. D. Fidler avait été recommandée par le Comité Administratif pour le poste de directrice de l'Ecole de Démonstration. On demanda alors à Mlle Fidler de rechercher les hôpitaux convenant à l'expérience de cette école.

Mlle Fidler présenta le rapport de ses v sites dans divers hôpitaux.

Il faut d'abord s'assurer que les élèves diplômées de cette école jouieront des privilèges de l'enregistrement provincial.

Dans la province de Québec, la nouvelle loi de 1946 exige que le cours ne soit pas moins de trois ans. Tout de même il serait possible que les diplômées de cette école soient enregistrées dans la province de Québec si elles sont déjà enregistrées dans une autre province.

Les écoles d'infirmières de l'Ontario sont actuellement à l'étude mais aucune décision définitive n'a été prise.

La nomination de Mlle Fidler comme directrice de cette Ecole de Démonstration a été confirmée.

COMITÉ DES RELATIONS DU TRAVAIL

Le travail du comité se rapporte aux questions suivantes: (1) méthodes de contrats collectifs; (2) rapport entre infirmières et syndicats; (3) questions dans les lois et règlements des Ministères du Travail Fèdéral et Provinciaux pouvant intéresser les infirmières.

Contrats collectifs: Il semble prouvé, après enquête, que légalement il n'est pas possible pour les associations provinciales, dans la plupart des provinces, d'agir comme agents négociateurs. Le comité est d'avis que d'autres méthodes doivent être adoptées dans les négociations collectives afin que cette responsabilité demeure entre les mains du groupe professionnel. Selon les informations obtenues, à date, au moins deux provinces ont obtenu que des représentantes de l'association soient certifiées comme agents négociateurs pour des groupes d'infirmières.

Relations entre infirmières et syndicats: Après une étude des relations entre infirmières et syndicats, le comité exprime encore une fois la même opinion que l'affiliation à un syndicat ne peut donner aux infirmières la compréhension et la force qu'elles trouveront dans leur profession.

Dans les organisations syndicales, la grève, étant un moyen légal employé pour obtenir des négociations collectives, ce seul fait suffirait pour montrer que cette organisation ne peut convenir aux infirmières.

Dans les rapports des comités, on a cité des cas où les infirmières s'étaient affiliées avec les syndicats en faisant partie d'associations d'employés. Dans certains cas nous sommes d'avis que les infirmières auraient bien mieux fait de prendre des directives de leurs associations provinciales et de ne pas se départir d'une ligne de conduite professionnelle; pour d'autres groupes nous comprenons bien qu'elles n'avaient pas d'autre moyen pour régler leur problèmes.

L'extrait suivant d'une lettre rappelle la situation, déjà rapportée dans ce *Journal*, l'Incident de Willesden, mais cette fois la chose se passe dans notre pays:

"La situation des infirmières du service de santé de Toronto est un problème local qui cause encore beaucoup de soucis. En décembre, un mémoire fut présenté au maire le pressant de faire reconnaître la revendication du groupe professionnel et que l'ordre, obligeant le groupe professionnel de faire partie des unions ouvrières, soit amendé.

"Hier, notre aviseur légal, notre présidente, et la convocatrice du comité des aviseurs de ce groupe, des représentants des médecins, dentistes, et d'ingénieurs se présentèrent au conseil de ville afin de demander, que lorsqu'une nouvelle entente sera faite en avril avec l'union des employés municipaux, que ces groupes soient exempts de l'entente et qu'il n'y ait aucune obligation de faire partie de l'union ou d'en payer la contribution."

Dans un projet de loi fédérale, concernant les Relations Industrielles et les Enquêtes sur les Différents, loi appelée à remplacer PC-1003 des lois de mesures de guerre, il est dit que si la majorité d'un groupe d'employés, appartenant au même métier ou à la même profession, sont organisés en union ouvrière, cette union peut être certifiée comme agent négociateur pour ce groupe d'employés.

De cette façon il se pourrait que les agents négociateurs nommés ainsi soient étrangers à la profession d'infirmière. Après avoir consulté notre aviseur légal, la motion suivante fut présentée:

Comme l'Association des Infirmières du Canada est d'avis que seuls les membres de la profession d'infirmière sont qualifiés pour faire des contrats collectifs au nom des membres de leur profession, et comme dans le nouveau projet de loi il n'y a pas les dispositions nécessaires à cette fin, il a été résolu de demander au Ministère du Travail du Canada que l'Article 10 de cette loi se lise comme suit:

"10 (1) Lorsque la majorité d'un groupe d'employés d'un employeur auront un métier ou une profession distincte des employés en général, ce dit groupe peut se former en une unité et peut demander à la commission que des membres de leur métier ou de leur profession soient certifiés comme agents négociateurs pour cette dite unité. (2) Que les employés de cette unité soient, s'ils le désirent, exclus de tout autre groupe pour contrats collectifs et que l'on ne tienne pas compte d'eux comme membre de tout autre groupe pour toutes les fins de cette loi."

Loi des Accidents de Travail protège les infirmières comme suit:

Alberta: Toutes les infirmières employées dans les hôpitaux appartenant au gouvernement provincial sont assurées contre les accidents. Plusieurs hôpitaux dans les villes et des hôpitaux municipaux ont les mêmes assurances, mais pas tous.

Aucune assurance contre la tuberculose.

Colombie-Britannique: Toutes les infirmières employées dans les institutions suivantes sont assurées contre les accidents: les hôpitaux recevant des subsides du gouvernement; les hôpitaux du gouvernement provincial; les hôpitaux privés; les services de santé des villes; les services de santé du gouvernement provincial; les industries soumises à la loi. Toutes les infirmières à l'emploi d'hôpitaux recevant de l'aide du gouvernement provincial, ou appartenant à ce gouvernement, sont assurées contre la tuberculose si la maladie se

déclare après six mois d'emploi.

Nouveau-Brunswick: Dans tous les hôpitaux les infirmières sont assurées contre les accidents. Les infirmières à l'emploi des services de santé des villes ne le sont pas.

Nouvelle-Ecosse: Aucun employé d'hôpital n'est protégé par la Loi des Accidents du Travail.

Saskatchewan: La Loi des Accidents du Travail protège les infirmières suivantes:

Toutes les infirmières dans les hôpitaux, hôpitaux privés, de convalescents, hospices pour vieillards, malades, ou indigents, et les oeuvres de l'enfance. Toutes les étudiantes infirmières sont incluses dans ce groupe. Toutes les infirmières employées par le gouvernement provincial et par les villes de Régina, Moose Jaw, et Saskatoon. Toutes les infirmières employées dans les industries soumises à cette loi. La tuberculose n'est pas considérée comme une maladie donnant droit aux indemnités prévues par la Loi des Accidents du Travail.

Loi de l'Assurance-Chomage: D'après les rapports reçus des provinces, cette loi suscite des mécontentements chez les infirmières qui y sont soumises.

Bourse d'Etude

L'Association des Infirmières du Canada annonce qu'une bourse d'étude de $500 est offerte, sous forme de prêt, aux infirmières afin de les aider à poursuivre des études post-scolaires. La demande d'infirmières qualifiées dépasse de beaucoup l'offre et un nombre adéquat de surveillantes, d'institutrices, et d'administratrices dans les hôpitaux et en hygiène publique est de première importance.

Ce prêt est fait aux infirmières afin qu'elles puissent se qualifier pour des positions importantes et être des chefs de ligne dans la profession.

Les infirmières en règle avec leur association provinciale sont éligibles et peuvent faire leur demande.

Le prêt est fait pour une période ne dépassant pas cinq ans. Il n'y a aucun intérêt pour les trois premières années; après ce temps un intérêt de 5 pour cent est chargé, et ce, jusqu'à remboursement complet.

Le remboursement doit se faire aussitôt que possible après que le cours post-scolaire est complété. Si la boursière cesse de pratiquer comme infirmière, la balance sur la somme dûe doit être payée immédiatement.

Toute infirmière qui obtient un prêt doit pratiquer comme infirmière durant un an au Canada.

L'on peut obtenir les formules de demande au Bureau National.

Résolutions

1. Il a été résolu que l'on procède de la façon suivante pour tout ce qui concerne les valeurs de l'association. Dans un cas d'urgence que la secrétaire-trésorière générale soit autorisée avec l'approbation de la présidente à prendre les mesures qu'elle juge nécessaire.

En l'absence de la présidente, l'approbation d'une des vice-présidentes d'après leur rang doit être donnée.

Dans le cas où la secrétaire-trésorière générale serait dans l'impossibilité de régler une situation urgente, que l'avocat nommé par la secrétaire-registraire se mette immédiatement en relation avec la présidente qui donnera les autorisations nécessaires après avoir conféré avec le Sous-Comité de l'Exécutif.

2. Considérant la question des articles écrits pour *The Canadian Nurse* qui sont en opposition avec la philosophie fondamentale d'un groupe reconnu dans l'association, il a été résolu qu'il sera demandé au comité de direction du *Journal* de définir sa ligne de conduite sur cette question.

3. Des lettres de protestations ayant été reçues à la suite de l'article "Guilt and Anxiety as Social Controls" il a été résolu que *The Canadian Nurse* publierait la déclaration suivante: Que les opinions exprimées dans l'article précité sont les opinions de l'auteur et que l'association n'appuie pas officiellement l'article qui présente l'interprétation de l'auteur.

4. Il a été résolu que l'on exprime à Monsieur W. B. Scott, conseiller juridique, l'appréciation du Comité Exécutif et ses remerciements pour les avis et l'aide qu'il a donné; que les mêmes sentiments sont exprimés à la direction du Ritz Carlton pour leur service courtois.

Wigs, made with nylon instead of hair, are in great demand in London, Eng., theatrical circles. The preference of nylon over hair wigs lies in the fact that nylon can be dyed to the most delicate shades without losing its lustre.

With UNRRA in Germany

(*Continued from page 532*)

break loose and float along the ocean fairways.

At a snail's pace we crossed the Channel, and made a landing at the ruined harbour of Ostend. What a thrill to set foot for the first time on the continent of Europe; but what a tragedy to behold the bombed and ruined buildings of that well-known port! Then came all the orderly disorder of disembarkation and, in an hour or so, we were driving towards Brussels where already, the Belgians, freed from the nightmare of years of occupation by the enemy, were spreading an air of resolute gaiety through their streets and cafes.

In Germany

Special road maps with marked and numbered routes leading from Brussels in Belgium to Bad Oyenhausen in Germany, the centre for the moment of the HQ of the 21st Army Group, BLA, offered alternative routes to our destination. We chose the one that ran through Louvain — scene of massacre and destruction in 1914 and later — across the Dutch border and on to Hatert, Nijmegen, and Arnhem, across the Rhine into Germany through Emmerich and Bocholt to Munster, and then by way of Rheda, Bielefeld, and Herford to Bad Oyenhausen.

At Hatert we had our first opportunity of meeting a large group of UNRRA people waiting, in what had formerly been a prisoner-of-war camp, for allocation to their various posts. Nijmegen had a particular interest to me as a Canadian for in the early morning (we spent the second night there) I walked through the debris of the terribly bombed streets to see the important bridge which the Canadians had so gallantly and successfully defended. It was a curious sensation to be actually in Germany, and to see the tremendous destruction of towns like Bocholt, hardly more than a mass of rubble; the notices on trees, fences, and so forth, warning of bombs, giving stern orders and prohibitions in English and German and, occasionally, ending with the grim words "Penalty—Death." In spite of its ruined houses and heaps of broken bricks, it was difficult to imagine that this beautiful farming country, where women, children, and a few men were working in the fields and harvesting the crops without the aid of machinery and farm animals, had so recently been the scene of the most savage fighting in the world.

As we proceeded, the devastation became even more intense. I shall never forget the drive through Munster, which was the first major city en route and which, being an important railway centre, had been a special target for the R.A.F. They had certainly done their job well! At Rheda we joined one of Hitler's famous highways — the *autobahn* — leading from Cologne to Berlin, and on that beautiful surface quickly reached Bad Oyenhausen to report for duty.

Establishing Headquarters

It is not necessary to tell the story of the establishment of our headquarters; the collection of information relative to conditions in the field; the locating of our personnel already on duty there; the winning of the confidence of the military authorities who were in sole command; and attempting always to carry out a constructive and co-operative program. Eventually, by much hard work and by the great administrative skill of our Zone Director, Sir Raphael Cilento, who had originally gone out as chief medical officer, opposition was overcome and a sound administrative structure gradually took shape. On November 27, 1945, an agreement — the first in the three zones and the one on which agreements in the French and American Zones were subsequently based— was signed between UNRRA and the Commander-in-Chief and Military Governor of the British Zone

of Germany — none other than Field Marshal Montgomery. In this agreement, responsibilities of the Occupation Authorities and UNRRA respectively were, for the first time, set out on a mutually satisfactory basis.

The British Zone of Occupation in Germany — one of the four into which the country was divided — comprises the northwestern and central western parts of Germany from the Danish border south to Cologne, and from the Dutch and Belgian borders eastwards as far as Lubeck in the north and Helmstedt in the south (Gottingen is in the British Zone and Cassel in the American). It covers an area about the size of England without Wales. Situated in it are the great coal-mining areas and the former centres of German industry. The area was said to contain some twenty-two million Germans, and when the war ceased there were over three million displaced persons in this British Zone alone. At the time of our arrival the number had fallen to 860,000 who were scattered over the country in nearly four thousand camps within approximately eight hundred "assembly centres."

Assembly Centres

The distribution of these camps was largely an accidental matter. In the early stages, units of the British Army, seizing towns and bringing under control every German area, had "frozen" all collections of displaced persons and had attempted gradually to assemble these into larger and larger groups. Within a few months, with UNRRA assistance, there were 210 of these assembly centres, comprising slightly more than 800 camps and, within a year, they had fallen to a total of 160, of which UNRRA controlled directly 104. UNRRA teams as they reached the field—and 250 had been sent for most urgently—were allocated each to a small army unit and worked under the direct control of the responsible officer, whether he was a colonel or merely a lieutenant. They had, at the beginning, no contact at all with other UNRRA units and no relation to the headquarters unit. Correction of this situation was one of the first requirements.

Jean Watt, Mary Wade, Myrtle Lindsay

Each team consisted of a director, various administrative and clerical officers, a doctor, a nurse, a welfare officer, supply officers, cooks, etc., with such increases as were necessary depending upon the number of displaced persons under the care of each team.

The refugees and displaced persons —DPs, as they were called—were collected in the assembly centres and might be as few as 1,500 or as many as 20,000. Naturally enough, the shelter provided was inadequate from the standpoint of room space, sanitation, and warmth, but, considering that the occupation authorities were also responsible for housing their own troops and for providing shelter for the thousands of German refugees who kept pouring into the Zone from the east, the accommodation provided was the best available. In this, as in many other instances, the occupation authorities did magnificent work under great difficulties.

Many of the assembly centres were established in what had formerly been German barracks. These were undoubtedly best from the point of view of sanitation, ease of administration, and general living conditions. Psychologically, however, the effect was not good for, necessarily, thou-

sands of people were crowded together under conditions all too similar to those they had experienced during the war as prisoners or forced laborers. The crowded conditions also contributed to the spread of airborne and parasitic diseases, to which further reference will be made later. On the other extreme, there were numbers of centres consisting of many scattered camps quite long distances apart. One assembly centre, for example, contained nineteen camps, the furthest of which from north to south were twenty-five kilometres apart and the furthest from east to west were sixteen kilometres apart! While the objections of overcrowding and concentration camp conditions were not present, lack of transport made delivery of supplies and administrative supervision extremely difficult. A very few centres were established in German villages, which had been taken over completely, or almost completely, by the DPS themselves. This was, of course, the most natural set-up, because programs could be developed precisely as they can in any village community. The disadvantage in this type of assembly centre was that people were so comfortable and so well cared for that they hesitated to leave such surroundings even to return to their homeland, since the homeland itself had become an unknown and distant country.

Immediate Problems

The immediate problems were three in number. The first and most urgent was to meet the threat of epidemic diseases; the second was to take over from the army some of its responsibilities in respect to displaced persons, really a civilian job; the third was to build up a proper administrative structure to which the army could, with confidence, hand over these responsibilities.

D.P. medical and nursing staff at Lahde Hospital (Baltics)

Danger of Epidemics

As mentioned above, overcrowding and poor sanitation, a gross lack of equipment and hospital facilities, and insufficiently trained junior personnel made airborne and parasitic diseases continual threats. Typhus, typhoid fever, diphtheria, scarlet fever, skin diseases — particularly scabies — tuberculosis, and venereal diseases were all of major importance; epidemics of typhoid and typhus were sweeping some areas; diphtheria of a very fatal type had been prevalent at the end of 1944, and it was feared might again become dangerously common. Scarlet fever was already beginning to show itself. Scabies was prevalent owing to the scarcity of soap, the great difficulty in obtaining ointment for treatment, and the crowding that provided great numbers of cases, all of which prevented immediate treatment and so permitted continued reinfection.

The first attack was made upon the typhus situation, particularly in those areas that constituted the border with the Russian Zone. Since European typhus is a louse-borne disease, the chief measure for control was the use of DDT. As it was impossible to control the movements of DPs, it was necessary to see that on every arrival and departure they were treated by dusting. Though the work was very imperfectly done, there is no doubt that it kept the incidence of typhus to a minimum, and prevented the epidemics which might so easily have occurred.

There were no facilities for immunization against scarlet fever, and it ran its course, but immunization against diphtheria and typhoid was started early. It was felt that if from one-third to one-half of the susceptible portions of the community were successfully immunized, no epi-

demic would result, or, if cases did occur, they would "smoulder" in the community rather than "blaze." This proved to be the case. Since the main period of typhoid incidence was in the spring, inoculation against this disease was made secondary to diphtheria, but the routine of typhus, diphtheria, and then typhoid was not always as clear-cut as this sounds.

Flying squads had been sent into the area earlier for the purpose of picking up wandering DPs and bringing them to assembly centres or, if necessary, to hospitals or feeding stations. This plan was very soon exhausted by the fact that the DPs were cleared from the roads, and the flying squads became of great value in the immunization campaign. Many team doctors and nurses had little knowledge of, or interest in, the public health aspects of the medical care program and often, as a result of their inertia, and also owing to the difficulty of obtaining supplies, the initiative in immunizing was taken by the flying squads. Finally, they were charged to deal directly with this situation, the squads being reorganized and each being provided with a doctor and two medical attendants. They visited the assembly centres and, with the assistance of the team doctor and nurse, demonstrated the method and gave the first series of inoculations. A follow-up visit was made later to see that the program was continued, and to give any necessary assistance.

Hospitals and Sick Bays

The second part of the program—taking over responsibilities from the army — consisted (1) in taking over the Belsen hospital and, ultimately, several other activities; and (2) in establishing proper medical facilities and sick bays in all assembly centres, with a gradual building up towards larger installations in the central sites.

A sick bay had to be set up in each centre, sometimes more than one if the camps making up the assembly centre were far apart. One of the major difficulties was the lack of transport and the consequent slowness

Polish nursing aide demonstrating baby bath to D.P. mother

in receipt of supplies. Each UNRRA team went out equipped with a certain quantity of supplies, but these did not stretch very far in the setting up of sick bays and clinics. The military government and the officers in charge of the various units were very generous if they had supplies on hand. The DPs themselves had secret sources of information, and were quite adept at providing the necessary items of equipment and drugs. No questions were asked as to the source!

From the sick bay, anyone who was really ill was sent to the nearest German hospital, in which a certain number of beds were reserved for DPs and were kept under the supervision of the UNRRA personnel. All maternity cases were supposed to be hospitalized in this manner, but frequently the baby was well on the way before the doctor or the nurse was notified.

In the early days there was a great reluctance to report illness because of the fear of hospitalization. The cruel circumstances of the war had given the word "hospital" a dread significance to many of the DPs. It was only because of their confidence in the health worker and her explanation of the fact that by reporting the first sign of illness the need for hospital care might be

averted, regular treatment facilities were ultimately established.

The British Red Cross Society had five hospitals caring for displaced persons, and, by arrangement, some hospitals—known as "DP hospitals"—were established and staffed almost entirely by DP personnel. The standards of medical and nursing care in some of the latter were adequate, but, in many, conditions were really alarming. It was very difficult to assess the qualifications of the so-called nurses, and in some hospitals probably not more than one or two of the "nursing" staff had ever had any form of professional training.

The first major activity taken over from the army was the Glynn Hughes Hospital at Belsen, the notorious Nazi concentration camp which became known throughout the world as a byword for atrocity. When this camp was liberated in April, 1945, there were thousands of sick and dying persons, and the magnificent work done by British Army doctors and nurses, and particularly that of Colonel Glynn Hughes for whom this hospital was renamed, is well known. The hospital had been established at Belsen in the building which had formerly served as a hospital for German officers. It was a 500-bed hospital, containing at the highest occupancy 900 patients; at the time it was taken over by us it had 690 patients. It was staffed by German doctors and nurses, under the supervision of British officers and nursing sisters. It was a condition of the transfer that the German staff should be retained, and that the UNRRA doctors and nurses would act in a supervisory capacity. There were 7 German doctors and 134 German nurses, of whom 119 were fully qualified. This hospital had a greater number of nurses per patient and a greater proportion of qualified nurses to unqualified nurses than any other hospital I visited in Germany. The care given the patients was of good quality, but Belsen had acquired a notoriety that caused it constantly to be a subject of criticism. One must, in all fairness, say a word of praise for these German nurses, who gave excellent nursing care to the displaced persons under conditions which at times were most humiliating and most difficult. There was much criticism from many sources of the continued use of German personnel but, aprt from the fact that this was the basis upon which the hospital had been transferred, it was not possible to obtain a sufficient number of qualified DP personnel in spite of the many statements made claiming that "hundreds" of qualified nurses were available. The very fact that it was the first large UNRRA responsibility made it necessary to maintain the highest possible standard under existing conditions.

(*Concluded next month*)

In Memoriam

Blanche Bibby, who graduated from St. Pancras Hospital, Highgate, London, Eng., in 1901, passed away in Vancouver on May 8, 1947. Miss Bibby served for over three years as a nursing sister during World War I. Holding a fever nurse's certificate, she engaged in tuberculosis work in Canada and the United States. She was superintendent of nurses at the sanatorium in Tranquille, B.C., prior to her retirement several years ago.

Enid Lenore Chadsey, a graduate with the class of 1930 of St. Paul's Hospital, Vancouver, died on April 25, 1947, after a brief illness. After engaging in private duty for a time in Vancouver, Miss Chadsey accepted the position as matron of the Abbotsford (B.C.) Hospital. Three years ago she was appointed matron of the Port Alice Hospital on Vancouver Island.

Mrs. Fred Milhim, of Hazel Cliff, Sask., who was a graduate of the Yorkton General Hospital, died recently after a long illness.

Nellie Miller, a graduate from Whitby (Ont.) Hospital in 1923, died recently in her forty-ninth year. Miss Miller had been in poor health for a long time and had been unable to practise her profession.

Jessie Wood Robinson died recently in Saint John, N.B., following a lengthy illness. A graduate of the hospital at Beverley, Mass., Miss Robinson had practised nursing for many years, both in Saint John and Montreal.

STUDENT NURSES PAGE

Gastric Ulcer

SISTER EVELYN CLARE

Student Nurse

Halifax Infirmary School of Nursing, N.S.

AN ambulance case admitted to our department was the focus of our interest. Mr. I, the patient, was a slight, pale, apprehensive, middle-aged man, who had apparently been unwell for a period of months. He confirmed our supposition by stating that he has been suffering from a gastric ulcer for years, but after many increasingly severe attacks the acute stage had evidently been reached.

There are many theories concerning the etiology of the gastric ulcer. Among these, the constitutional factor is fundamentally essential; and, while the role of inheritance is uncertain, ulcers are of frequent instance among parents, brothers, and sisters. Chronic ulcers in men usually occur between the ages of twenty and fifty, supposedly caused by the digestion and destruction of a region of the mucous membrane by the activity of the gastric juice. Irregular living habits, emotional strains and temperaments produce a tension which, through the autonomic nerves supplying the stomach wall, affect a change in the mucous membrane so that it may be more easily digested by the gastric juice.

The characteristic symptom of gastric ulcers is pain, which is typically related to food ingestion, and is chiefly of a burning and boring character. This pain is the result of irritation of the lesion by the gastric acid secretion; and the relief obtained from food or anti-acids is due to partial neutralization of the acidity. Vomiting and hematemesis are frequent ulcer symptoms, but are not always present. In addition, tenderness is usually noted in the epigastrium on physical examination; a gastric analysis reveals hyperacidity; and x-ray films show suggestive changes in the organ concerned.

Mr. I was fifty-three years of age, married, with two children. Being a commercial artist, he was constantly under the strain of "meeting deadlines," and found this very nerve-wracking, especially in his present health. For the past twelve years, he had been suffering from attacks of epigastric pain, becoming of late increasingly more severe, and causing a weight loss of nineteen pounds in eight months. Previous to this attack, relief was obtained from anti-acids and hot milk, but now no comfort could be secured. It is of interest in this case to realize that Mr. I's mother, brother, and sister all suffer from "stomach trouble." His physical examination on admission revealed only one significant finding — that of epigastric tenderness.

On the evening of admission, morphine gr. ½ subcutaneously and codeine gr. ½ orally were administered for pain. Anti-acid powders were also ordered, but the respite from

pain was short and soon our patient was restless and suffering once more. The following day the first stage ulcer diet was ordered. In our hospital this would ordinarily be as follows:

1. Feedings every two hours.
2. Alternate feedings of milk, malted milk, and lactose milk.
3. Alternate feedings of milk with egg.
4. Anti-acid powder every two hours midway between feedings, with an added amount at bedtime.

I stress "ordinarily" because in this case enforcement of the diet was impossible due to the unco-operative attitude of the patient and his refusal to eat. Only after much resourceful persuasion would he partake of the nourishment.

Mr. I was urged to relax and rest as much as possible for the next few days. A fractional gastric analysis was then performed in which the only pathology noted was "hyperacidity" in both the free hydrochloric acid and total acidity tests. In view of the significance of this test, Dr. M, foreseeing future surgery, ordered the second stage ulcer diet, his aim being to improve the patient's general physical condition, because at the present Mr. I was a "poor operative risk." Foods included in this slightly graded diet were: soft-cooked cereals, in small servings, custard, gelatin, tapioca, soft-boiled egg, slice of bread and butter. Anti-acid powders were taken every hour during the day with a larger quantity at bedtime.

As Mr. I continued to improve physically, the nurse's responsibility was to aid him in every possible way to regain his emotional stability and peaceful attitude of mind. This she accomplished to a marked degree by her truly sympathetic and understanding manner of approaching the nervous temperament to which the past years of discomfort had subjected him. She reasoned quietly with him, stressing the importance of frequent feedings, the monotonous diet, and the necessity of rest. At times her efforts on his behalf were well rewarded; at others, Mr. I was irritable and indifferent to the acquisition of health and future happiness.

Though confined to bed, there were repeated attacks of epigastric pain often accompanied by vomiting. Pantopon was administered hypodermically for the severe seizures, while demerol was ordered for those less painful. Anti-acid powders and milk of bismuth were continued as the patient required them.

The third stage ulcer diet, now introduced, allowed the patient:

Breakfast: Small serving of cooked cereal, equal parts of milk and cream, piece of buttered toast, weak tea or cocoa.

Dinner: Creamed soup, ounce of minced chicken, crackers, weak tea, milk or cocoa.

Supper: Chicken soup or bouillon, soft-boiled or poached egg, two pieces of buttered toast, milk.

Midlunches: Choice of eggnog, milk, or flavored milk with crackers.

An x-ray of the stomach was taken at this time, the report of which stated, "the ulcer previously noted in the lesser curve has increased tremendously in size, and measures one and one-half centimeters deep, and over three centimeters long. The edges are rolled and there appears to be infiltration of the adjacent stomach wall." Malignant degeneration was feared at this stage. The expression, "ulcer previously noted," refers to the x-ray taken one year earlier, when a "penetrating gastric ulcer was seen on the lesser curvature between the pylorus and cardiac end," and also, to that of six months ago, when the ulcer was reported to be larger and plainer, but evidenced no malignancy. From these reports we may remark the rapid progress of the degenerative changes.

Instead of the former dietary problems, Mr. I now presented a more responsive attitude, and soon proceeded to the fourth stage diet which included those foods formerly allowed, in larger servings, with additions of mashed potatoes, strained vegetables, boiled or baked fish and white meat of chicken.

When gastric ulcers fail to heal under adequate medical treatment,

surgery is the necessary alternative. Mr. I's condition was of this character, therefore on the day prior to his operation he received the following preparations:

1. Two intravenouses of saline 1000 cc., as a preventive measure.

2. Intravenous of amino acids in distilled water. Amino acids are food, equivalent to digested protein, and are offered as a substitute when the patient is unable to secure adequate protein.

3. Blood was grouped and cross-matched in the event of a possible transfusion.

4. The Levine tube was inserted for lavage of the stomach but this operation was unsuccessful as Mr. I would not retain the tube. Because of this, the Wangensteen suction was ordered on the morning of the operation to remove the accumulated materials, and to provide a clean operative field.

5. A saline enema and a high abdominal skin preparation completed the preliminary procedures.

After many friendly, candid conversations with Dr. M, Mr. I was completely convinced, and greatly confident that surgery would be the best treatment for his condition. This attitude helped to ensure the success of the operation. On the morning appointed, the final preparations were completed, and pantopon gr. ⅓ with hyoscine gr. 1/150 was administered as medication. The anesthetic used was sodium pentothal, and the operation commenced.

Through a high left paramedian incision the abdomen was opened. "An indurated mass was felt on the lesser curvature of the stomach, about two and one-half inches from the esophagus. An ulcer was felt in this mass. No definite induration, no stony hardness, no involvement of the peritoneum, and no glandular enlargement were noted."

The usual surgery for the above findings would be total or subtotal gastrectomy, gastroenterostomy or pyloroplasty but, because of the patient's condition, Dr. M considered a total gastrectomy too formidable and performed a vagotomy. "Both vagi nerves were isolated, and about two inches of each resected with ends ligated." Some years ago, it was demonstrated, in the treatment of gastric ulcer, that "after section of the vagi, gastric ulcers were not produced by direct electrical stimulation of the tuber centres of the infundibulum," thus theorizing that stimulation to the stomach by the vagus nerve branch was a fundamental cause of the ulcer, and that after section of the nerve no stimulation occurred. The reason for this supposition is based on the fact that the central nerve supply is through the vagus which contains both motor and sensory fibres to the muscles of the stomach. Dr. M's object in performing this newer method of surgical ulcer treatment, in use only within the last decade, was to reduce the hypermotility and hyperacidity of the stomach caused by the vagus, and to afford rest to the part, allowing the lesion adequate environmental conditions for healing.

During the operation, a blood transfusion was given and Mr. I's state throughout was good, as also was his post-operative condition. The Wangensteen suction was resumed for six days, penicillin 620,000 units ordered, and a daily intravenous of glucose and saline administered, all as post-operative measures. In addition to the ordinary nursing care, including daily skin cleanliness, oral hygiene, frequent positional changes, a sympathetic and pleasant manner demonstrated by those in charge of the patient, aided in hastening his recovery.

A minor complication appeared about one week later, that of occasional attacks of diarrhea, but this symptom had been expected by Dr. M who explained that this was the one debatable point in regard to a vagotomy. He proceeded to treat the condition by a prescription of hydrochloric acid and milk of bismuth, so that when Mr. I was discharged this weakness was well under control. There were also days of extreme nervous irritability and emotional depression which resulted in a refusal to eat or to rest, despite the efforts and solicitude of the entire staff. At times, Mr. I was considered a "difficult

patient," but responded fairly well to gentle and tactful management. After nine days, several sutures were removed, the incision healing by primary intention, and the patient was permitted out of bed for lengthening intervals. During this convalescence, his appetite improved until in a few weeks he was on a general diet, excepting, of course, for flatus-forming, harsh foods. Automobile drives taken with his family were a considerable encouragement for Mr. I.

Another fractional gastric analysis was performed and revealed an almost unbelievable decrease in the stomach acidity. More encouraging still was the x-ray report of this time, just three weeks after his operation, which stated: "There is definite decrease in the size of the ulcer in length and depth. The appearance is that of a rapidly healing ulcer."

On the day of his discharge, Mr. I presented a very much improved appearance from that of the evening of his admission. Though yet slight in stature, his countenance and general demeanor expressed a certain confidence in his recently acquired freedom from pain and discomfort. At present, Mr. I is enjoying normal health, while yet convalescing, is regaining former weight by means of rest and a nutritious diet, and is considering resuming his work. When Dr. M re-checks the healing progress by x-ray at some future date, we trust it will provide encouragement for the treatment of gastric ulcer by a vagotomy.

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The Resuscitation of the Drowned

E. J. PAMPANA, M.D.

It may be said that the method of artificial respiration which is the best known and the most frequently used today is the Schäfer method. In order to obtain effective results, by means of the Schäfer method, it is necessary that elasticity, or, more exactly, muscular tone be maintained. When using this method, the hands are placed close together flat on the back over the loins, the fingers extending over the lower ribs, and a gradually increasing pressure is exerted during three seconds. On relaxing the pressure, the chest resumes its former shape and size, so that the volume of air entering the lungs is equal to that forced out by the pressure. This inspiration is brought about naturally by the tone of the muscles, when they resume the normal position. Unfortunately, in a great many cases where artificial respiration is necessary, muscular tone decreases progressively; this is the case with drowning victims. Moreover, with the Schäfer method, the weight of the shoulders, the spinal column, the shoulder-bones, and the dorsal muscles opposes inspirations, and constitutes an obstacle which is all the more serious due to the decreased tonus of the respiratory muscles. In fact, it has been suggested that a second operator should help by lifting the folded elbows of the patient whose forearms remain extended. This system is used in the Holger-Nielsen method of artificial respiration—a method which combines forced expiration and inspiration and which, therefore, is not altogether dependent upon muscular tone. This method however, is not yet universally known, although it is used in Denmark, Norway, and the U.S.S.R.

During the recent war, which offered such wide opportunities for the practice of methods for the resuscitation of the drowned, certain criticisms of the Schäfer method were voiced.

For example, Gibbens (1942) wrote that, instead of the normal inspiration to be expected each time he interrupted the pressure, he had the feeling that the thorax and abdomen of the victim "felt like putty."

By rendering the breathing as independent as possible of the muscular tone, the Eve method (1932) would seem to be recommended for the resuscitation of the drowned. This is the system known as the "rocking method." The patient is placed face downward on a stretcher which has been mounted on either a trestle or support or attached by the sides to two cords suspended from the ceiling. The patient is then rocked on the stretcher at the rate of twelve double rocks a minute, with oscillations of from 60 to 90 degrees. These oscillations displace the weight of the abdominal contents, so that the latter alternately pushes and pulls the diaphragm, by a mechanism comparable to that of a piston operated solely by weight. As a matter of fact, it is the weight which causes expirations and inspirations, and this latter does not in any way depend on muscular recoil. The lungs are, therefore, excited exclusively by the diaphragm which, even when completely flaccid, still operates as a piston which is pushed towards the head when the head is lowered, and in the opposite direction when the head and thorax are raised. The diaphragm is the really indispensable muscle for breathing, and the object of the Eve method is to re-establish the working of the diaphragm.

Nevertheless, it is difficult to prove that the rhythmical movement of the diaphragm, in so far as it is caused by this method, induces pulmonary ventilation equal or superior to that caused by Schäfer's method, as Eve and Killick believed to have shown (1933). The results given by them have been subjected to criticism. The solution of this problem is difficult, since the volunteers who submit to artificial respiration tests, by voluntarily holding their breath, frequently do not succeed in maintaining an absolute respiratory passivity for the whole course of the experiment. Recourse can be had to patients submitted to profound anesthesia, in whom apnea (cessation of breathing), following exaggerated respiratory exchanges for a few minutes, is induced; experimental evidence in this direction, however, is still too scanty. The ideal method would be to experiment on the bodies of persons (who have died unaffected by any disease likely to vitiate the mechanism of the pulmonary ventilation) provided that the corpse is still warm and not yet rigid. All this is easy to imagine but less easy to carry out, although attempts are being made in hospitals to control the Eve method, by combating all the necessary conditions. Finally, there is another way of comparing the efficacy of methods of artificial respiration: that adopted by Hemingway and Neil (1944). They carried out experiments on dogs, in whom action of the respiratory centres had been made impossible, either by the transverse section of the spinal cord between the first and second cervical segments, or by a profound anesthesia with nembutal continued until cessation of breathing. In both cases, of course, the animal dies if not given artificial respiration. These latter experiments, which have confirmed the fact that in order to assess a method of artificial respiration it is not sufficient to limit oneself to a comparison of pulmonary ventilation, have established that with the "rocking" method a higher rate of oxygen absorption was ascertained together with a greater cardiac output and a higher oxygen tension in the venous blood, than in the case of Schäfer's system as applied to dogs.

These results are particularly interesting as they provide us with data concerning the oxygenation of the blood and concerning the circulation, two factors which are as important as mere pulmonary ventilation for the purpose of reviving drowned persons.

The aim of every method of artificial respiration is to maintain or to re-establish the respiratory exchanges in the central nervous system, that is to provide it with oxygenated blood.

Now, in the case of drowned persons, the general hypotonia of the muscles does not facilitate the return of the venous blood to the heart. Schäfer's system obviates this disadvantage by the compression of the abdominal veins, which occurs during the phase of forced expiration. According to its author, the Eve system is an improvement, as it forces back to the heart first the blood of the upper part and then the blood of the lower part of the body, and the valves in the veins prevent a reflux of the venous blood towards the extremities. The alternation of pressure in the thorax caused by this method can also facilitate the filling as well as the emptying of the blood from the lungs, going to the heart. Moreover, Eve believes that the cerebral congestion which occurs every time the head is lowered facilitates the functioning of the respiratory centre, which, according to the experience of anesthetists, restarts working with difficulty unless it is congested.

In practice, it may not always be possible to apply immediately the "rocking" method to a drowned person who has only just been rescued from the water. It is necessary to begin with one of the manual methods, and generally it is Schäfer's system which is recommended for the drowned, although one might well ask oneself whether Sylvester's method would not sometimes be preferable, since certain experiments on corpses in which rigidity has not yet set in show that the latter system induces a pulmonary ventilation far superior to that obtained by Schäfer's system. In the meantime, the stretcher can be prepared for rocking and the victim may be placed thereon, without of course ceasing manual respiration until rocking has commenced.

Several types of stretchers or devices have been suggested for rocking.

The War Memorial Trust Fund

Elsewhere in this issue, we have reproduced the dedicatory address and the photograph of the Memorial erected to the memory of the nurses who served in World War I. It is proposed to affix a suitably inscribed plaque to this panel to commemorate the nurses of World War II. In addition, the larger, more far-reaching memorial which was decided upon at the last biennial meeting of the Canadian Nurses' Association, that of sending professional libraries to the war-ravaged countries of the world, awaits your donations. As announced in the February, 1947, issue of this *Journal*, the provincial allocations for this purpose were as follows:

Alberta	$ 2,000
British Columbia	3,700
Manitoba	2,000
New Brunswick	900
Nova Scotia	1,600
Ontario	10,000
Prince Edward Island	200
Quebec	10,000
Saskatchewan	1,600
Total	$32,000

Donations that have been received at the National Office, C.N.A., show the following totals as of June 6, 1947:

Alberta, $1,022; *British Columbia*, $705; *Manitoba*, $1,266.50; *New Brunswick*, $677.35; *Nova Scotia*, $401; *Ontario*, $3,103; *Quebec*, $78.08; *Anonymous*, $6.00. *Total*, $7,258.93.

How did your province contribute to the first Memorial? From the report of the late Miss Jean I. Gunn, who was convener of the first committee, we may read in the October, 1926, issue:

"The first estimated cost of the Memorial was $65,000, but in April, 1923, after the definite site had been decided and a more definite idea as to the actual type of sculptured panel was possible, the estimate was reduced to $35,000. The objective assigned to each provincial committee was based on the membership of the provincial association and was as follows: British Columbia, $7,000; Alberta, $2,350; Saskatchewan, $2,350; Manitoba, $1,400; Ontario, $13,500; Quebec, $5,600; New Brunswick, $1,400; Nova Scotia, $1,400; Prince Edward Island, no definite objective as there were so few nurses to contribute.

"The provincial committees adopted many ways of securing the necessary funds but no public appeal was made. The contributions came from nursing organizations, student groups in training schools, and very largely as contributions from individual nurses. The final treasurer's report shows: British Columbia, $4,840.40; Alberta, $1,822.95; Saskatchewan, $3,376.44; Manitoba, $2,026.29; Ontario, $15,870.09; Quebec, $7,293.63; New Brunswick, $1,174.95; Nova Scotia, $871.19; Prince Edward Island, $324.90. Individual subscriptions from nurses in United States, $15.00. Total — $37,615.84. It will be seen by this total that the funds collected amounted to $2,615.84 more than the objective set at the beginning of the campaign."

Over $37,000 raised by less than half as many nurses as we have in Canada today! Let us see if every province cannot surpass the minimum objective listed above. It is worthwhile!

Special Flash!

Word has just been received from Ottawa that these donations MAY BE DEDUCTED FROM THE INCOME TAX. Swell your original donation and remember where you have put your receipts!

Preview

How did man discover that some plants possessed properties that would assist him in his recovery from illness? No one knows but a man who does know a great deal about the cultivation of these plants has written a most interesting and copiously illustrated account of the herb garden in Niagara Falls which we shall have much pleasure in presenting to you very soon. **George H. Hamilton, B.A., M.Sc.,** is botanist with the Niagara Parks Commission and he knows his herbs.

News Notes

ALBERTA

Calgary General Hospital:

At the twelfth annual reunion and banquet of the Calgary General Hospital Alumnae Association fifty-seven members of the 1947 graduating class were received into the organization. Millicent Lisson, president of the alumnae, welcomed the new members, following which the traditional "Big Sister, Little Sister" candle-lighting service was conducted. Marjory Bugler, president of the new class, extended the graduates' thanks to the alumnae. Mrs. T. L. O'Keefe brought greetings from the hospital board and introduced Mrs. F. A. Campbell, president of the newly-formed hospital auxiliary. Lillian Bibby proposed the toast to the absent members and greetings from out-of-town nurses were brought by Mrs. T. Kuzyk. Una Dale proposed the toast to the training school staff to which the superintendent of nurses, Anna Hebert, replied.

At the head table were the mothers of three of the graduating class: Mrs. F. W. Hicks (1924), mother of Deveney; Mrs. Carl Staples (1925), mother of Shirley; and Mrs. Frank Crisall (1920), mother of Marjorie.

Following dinner a varied program was enjoyed, including a humorous skit, entitled "Aseptic Wedding," conducted by Mrs. G. Duthie. Mrs. R. Cunniffe contributed two songs, assisted by Muriel McLean at the piano.

More than 290 members of the alumnae were present, including many from Vancouver, Edmonton, Red Deer, Lethbridge, and other distant parts. Mrs. A. E. Wilson was the able convener.

EDMONTON:

Thirty members were present at a recent meeting of Edmonton District 7, A.A.R.N., when Madeline McCulla presided. Rita Ball gave a comprehensive account of the A.A.R.N. annual meeting. A tea was held in May in aid of the Rest-Break Homes in England and for food parcels to British nurses. V. Chapman was the convener for this event.

Royal Alexandra Hospital:

The president, Mrs. N. Richardson, was in the chair at a regular meeting of the Royal Alexandra Hospital Alumnae Association, when twenty-five members were present. Mary Bell gave a report of the A.A.R.N. annual meeting. Margaret Cawsey was awarded the alumnae scholarship for 1947. Miss Cawsey intends to take a course in pediatrics in Montreal.

MEDICINE HAT:

Charlotte Joan Anderson, a graduate of the Royal Victoria Hospital, Montreal, and formerly with the R.C.A.M.C., has received her diploma in public health nursing from the University of Alberta School of Nursing.

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WEST KOOTENAY DISTRICT:

Springtime, progress, and inspiration were the keynote of the seventh annual dinner meeting of West Kootenay District, R.N.A. B.C. Flora McLean, in charge of registration, reported 90 nurses present — 55 from Trail, 21 from Rossland, 13 from Nelson, and one from Salmo. Mrs. Gavrilik, the retiring president, paid tribute to the Rossland Chapter in her opening address, stating that just over two years ago they had reorganized their chapter through the efforts of Flora McLean with the assistance of many enthusiastic members, and they have given a splendid example of what can be accomplished with co-operative workers. Mrs. Gavrilik welcomed Vera Eidt and Alice Bush, who were on the executive in 1941, back to Kootenay District. A special greeting was issued to Mrs. Crowthers, of Nelson, sixty-nine years a graduate, who travelled 108 miles to attend the dinner. Reports were given on the district's finances and concerning each chapter's activities.

F. A. Kennedy, P.H.N., gave an interesting talk on "Labor Relations," and then Mrs. T. B. McMillan was introduced as guest speaker. With her husband, the Rev. McMillan, she has spent twenty-five years in the mission fields in India. She was attired attractively in native costume and held her audience spellbound as she told of her life in India.

An interesting feature of the meeting was the display of an original photograph of Florence Nightingale, loaned by Mr. L. Bloomer, of Castlegar.

The officers for 1947 are: President, Mrs. W. Miller; vice-president, F. McLean; secretary, Mrs. M. Miller; treasurer, F. A. Kennedy; public health, Nancy Lee.

CHILLIWACK:

At a meeting of Chilliwack Chapter, R.N.A.B.C., plans for a tea and display of arts and handicrafts were outlined by Mrs. E. Roberts, entertainment convener. Mrs. Roberts, who was the delegate to the R.N. A.B.C. annual meeting, gave the highlights of the proceedings in an interesting report covering the changes in student nurse education and in personnel practices for graduates. Parcels are being sent monthly to British nurses.

The Chilliwack General Hospital was open to the public on the second Wednesday in May when tea was served. Thirty-six nurses attended in uniform the Memorial Service held at Carman United Church, Sardis.

Mrs. Steve (Laycraft) Tachit, public health nurse for Agassiz, has resigned.

ROSSLAND:

F. A. Kennedy presided at a meeting of Rossland Chapter, R.N.A:B.C., when Mrs. J. Lilburn was welcomed as a new member. Mrs. W. C. Stevens gave a report on the Jubilee Carnival meeting, and it was decided that members would lend assistance during Carnival Week with first aid and would conduct a Baby Contest. Mrs. R. McAllister

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reported on the Red Cross home nursing classes. F. McLean gave a summary of the R.N.A.B.C. annual meeting and discussion was led by Miss Kennedy who also attended. A donation was made to the War Memorial Trust Fund. At the close of the business session, R. E. Plewman showed films of Kootenay scenic beauty spots. Refreshments were served by Mmes P. Priestley and J. S. Roberts.

TRAIL:

Proceeds of the recent Hospital Day tea, plus fifty dollars donated by Trail Chapter, R.N.A.B.C., will go towards the War Memorial Trust Fund sponsored by the C.N.A., it was revealed at a regular meeting. Betty Kirkpatrick gave a report on the R.N.A.B.C. convention.

The Nurses' Memorial Service was held at the United Church on the second Sunday of May.

VANCOUVER:

St. Paul's Hospital:

At a recent meeting of St. Paul's Hospital Alumnae Association Mrs. McQuat gave an interesting report on the R.N.A.B.C. annual meeting. Twenty-five dollars is to be donated to the Cancer Campaign and the same amount is to be given to the War Memorial Trust Fund.

Norah Burke has returned from Kelowna and is again on the staff. Marian Abercrombie has resigned from the surgery staff and hopes to take a post-graduate course in pediatrics in the east. "Doss" McKay is leaving to accept a position in Honolulu and Miss Small to go to Pasadena, Calif. Mrs. (Campbell) Malcolmson, formerly on the surgery staff, is now living on Salt Spring Island. Pauline Armstrong and Miss Conroy have accepted positions at Kimberley, and Miss Fletcher and Ruth Brooks are off to Denver, Colorado. Myrtle Gracey is now teaching practical nurses in connection with the Department of Veterans Affairs.

MANITOBA

BRANDON:

The Brandon Graduate Nurses' Association recently entertained at dinner when the special guests were the graduating class of the General Hospital and the affiliated course of the Mental Hospital. Nan Crighton presided while Mrs. J. Fargey was pianist. Blanche Brigham was the general convener.

Following the toast to the King, C. Wedderburn proposed a toast to the graduates and Luella Cook voiced the appreciation of the class for the good wishes expressed. Mrs. R. Mitchell proposed the toast to absent members. Edythe Wood was the guest speaker when her topic was "The World I Live In."

Janet Smith and Marjorie Trotter reported on the past year's activities and N. Crighton and M. Hutchinson gave a review of the M.A.R.N. convention.

The new slate of officers includes Marion Patterson as president, with Mrs. E. Griffin as vice-president. The secretary is Mrs. R. Mitchell with Mrs. W. Brown as treasurer.

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NEW BRUNSWICK

MONCTON:

One hundred and twenty-five were present at the dinner given by the Moncton Chapter, N.B.A.R.N., in honor of the graduating classes of Moncton Hospital and Hotel-Dieu de l'Assomption. Mrs. Roberta Perry presided at this enjoyable event. Miss A. J. MacMaster, superintendent of Moncton Hospital, proposed the toast to the new group of graduates. After dinner, a dance was held by the Nurses' Hospital Aid in honor of the 1947 classes.

SAINT JOHN:

Mary Downing, president of Saint John Chapter, N.B.A.R.N., was in the chair at a recent meeting, when plans were made for the provincial annual meeting to be held in September. The guest speaker was Mr. Paul Barry.

Thirteen members were present at a supper meeting of the Public Health Section, Saint John Chapter, when Muriel Clark presided. The special speaker was Mr. Travis Cushing, guidance officer for the Saint John City Schools, who gave an instructive talk on "Child Guidance."

The annual ball, given by the Private Duty Section of the local chapter, proved a delightful success. Martina Carey and Margaret Wilcox were the able conveners.

Mrs. (Crossman) Mooney attended the I.C.N. Congress. Louise Cadorct is on the operating-room staff at the General Hospital.

ST. STEPHEN:

At a recent meeting of St. Stephen Chapter, N.B.A.R.N., held at the home of Mrs. H. Lawrence, it was voted to continue soliciting donations for the War Memorial Trust Fund. It was revealed that the food sale was successful. A "Pound Party," at which 60 lbs. of canned foods and dried fruits were packaged and sent to a Chipman Memorial Hospital graduate living in England, was a recent activity of the chapter.

The dance, given by the C.M.H. hospital board of directors for the staff and students, proved an enjoyable event. Thelma Briggs presided in the absence of the superintendent, Miss Follis. Jessie Orr, C.M.H. dietitian, planned a hike to Porter Mill Stream for the new class of students when a great time was had by all cooking over an open fire and fishing. Myrtle Dunbar attended the conference of public health nurses held in Fredericton.

On Nurses' Memorial Sunday, thirty-six nurses attended the service at Christ Church when flowers were placed in memory of departed nurses.

ONTARIO

DISTRICT 1

Nurses from four Western Ontario centres were well represented at the I.C.N. Congress held at Atlantic City. There were approximately nineteen attending from London,

six from Sarnia, and two each from St. Thomas and Woodstock.

LONDON:

Victoria Hospital:

The brightest spot in the yearly activities of the alumnae association of Victoria Hospital was the dance given in honor of the graduating class. Hilda Stuart, superintendent of nurses, and Margaret Stephenson, the alumnae president, were among those receiving the guests. A year's alumnae membership was presented to each graduate. Irene Van Camp was the convener in charge of arrangements.

A bridge was held by the association to raise donations to the War Memorial Trust Fund. The executive was in charge of arrangements.

SARNIA:

The Sarnia General Hospital and training school were recently honored by a visit from the Governor-General and Viscountess Alexander. The student nurses formed a guard of honor in front of the hospital and Rahno Beamish, superintendent of nurses, Mildred Weir, assistant superintendent of nurses, and Sarnia officials welcomed Their Excellencies and accompanied them on a tour of the hospital. Among those presented to the distinguished visitors were several nursing sisters including Margaret Pateman, Ida Rothwell, Margaret Anderson, Mrs. (Bloomfield) Curts, and Mrs. (Empey) Williams.

The Vice-Regal entourage visited the classroom where a class was in session under the direction of Helen McCarty. On behalf of the students, Miss McCarty presented Their Excellencies with a copy of the Calendar and Year Book of the school.

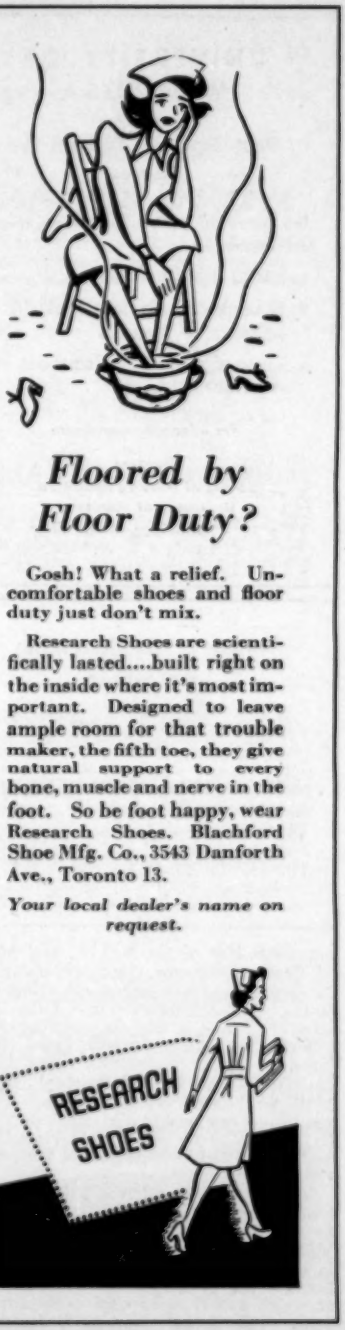
DISTRICT 4

NIAGARA FALLS:

Catharine O'Farrell presided at a regular meeting of Niagara Peninsula Chapter, District 4, R.N.A.O., when plans were discussed for the meeting of the district to be held here on September 10. Miss O'Farrell reported on the R.N.A.O. annual meeting and E. Robson on the I.C.N. Congress who were heard with interest by the members. The guest speaker was Dr. E. T. Kellam, who told his listeners some of the duties of a coroner, discussing the histories and tragedies with which he is confronted and called upon to investigate. He dealt briefly with the problem of infanticide which he stated appears to be increasing and which the government is endeavoring to eradicate. After the meeting K. Easton delighted the members with witty recitations when refreshments were served.

ST. CATHARINES:

From all over the Niagara district Victorian Order of Nurses staff and board members recently gathered to honor two prominent nurses — Miss Elizabeth L. Smellie, retiring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superintendent of the V.O.N., and Miss E. M. Crothers, director, Queen's Nursing Order for Great Britain and Ireland. The board of the St. Catharines branch of the V.O.N. acted as hosts at the banquet which was attended by representatives from Niagara Falls, Welland, Merritton, Thorold and Lincoln County. H. J. Carmichael, chairman of the local board, presided. Guests included members from boards and staffs of V.O.N., Dr. D. V. Currey of St. Catharines-Lincoln health unit, and Dr. Sturgeon of Welland and vicinity health unit.

In her address, Miss Crothers, who recently concluded her Canadian visit, pointed to the similarity between the work of the V.O.N. and her order in Britain. However, in Britain the work is much more extensive because the order handles childbirth cases of which 83,000 cases were undertaken last year. The Queen's Nursing Order consists of 2,500 branches with a staff of 8,000.

Miss Smellie, introduced by Mr. Carmichael, said it was an inspiration to see so many men active in V.O.N. work along with the women. Such work needed the partnership of men and women and all members of the community.

Guests were received by Mr. and Mrs. Carmichael, Mary Ferguson, district supervisor, Miss Crothers and Miss Smellie. Mayor W. J. Macdonald welcomed the guests and the two distinguished visitors to the city.

District 5

Toronto:

Women's College Hospital:

Dr. Gordon Agnew was guest speaker at the annual dinner given for the graduating class by the Women's College Hospital Alumnae Association. The president, Joan Davis, welcomed the 1947 class into the association, with Mary Elliott proposing the toast to the new graduates which was responded to by Corinne Weams. Mr. Peter Sandiford brought greetings from the hospital board, with Dorothy Macham and Laura Lambe also extending their best wishes. Dr. Agnew's talk on his many interesting experiences in China was much enjoyed by all present. Betty Brown thanked the speaker.

A County Fair was recently held by the association.

District 7

Brockville:

Attending the I.C.N. Congress were Misses Best and Preston.

Kingston:

C. Lankin was in the chair, in the absence of the president, at a recent meeting of Kingston Chapter, District 7, R.N.A.O. L. D. Acton agreed to receive donations for the War Memorial Trust Fund. An interesting report of the R.N.A.O. annual meeting was given by A. Davis. Miss Acton introduced the guest speaker, Dr. R. C. Burr, who is director of the cancer clinic at the General Hospital. His talk was entitled "Cancer Can Be Cured."

Ella G. Smith, Dorothy Morgan, and Mabel Fairfield were representatives at the I.C.N. Congress from Kingston.

At the recent convocation two young women received the first B.Sc.N. ever presented by Queen's University.

Forty-nine nurses from the General Hospital, thirty-two from the Hotel-Dieu, and thirteen from Ontario Hospital graduated during the past months.

Ontario Hospital:

The Ontario Hospital Alumnae Association have had several interesting speakers at their meetings during the past months. Dr. Grant Beacock told of the "anxiety" phase experienced by the men of the R.C.A.F. while on active service, and outlined the treatment

used in such cases. "Pediatrics" was the subject of Dr. F. D. O'Connor, Jr.

A successful Spring dance, convened by Mr. Herman Smith, was held at Cottage Inn to raise funds for the alumnae's various projects. The Recreation Club, formed last fall, with Mr. W. Newman as president, has proved popular, featuring badminton, ping pong, cards, games, music and drama. The club has also sponsored several successful dances.

Five preliminary students were "capped" at the recent exercises when Dorothy Morgan, assistant superintendent of nurses, gave an inspiring talk on what the future holds for nurses. Two male nurses also received hospital crests along with the young ladies who received their caps.

At the R.N.A.O. annual meeting the following were representatives from the hospital: Jessie Chalmers, Leila Bresee, Elizabeth Lyon, Mrs. B. Pomeroy, and Mr. C. H. Smith.

Mrs. G. Robins, from Ottawa Civic Hospital, is now on the staff. Marie Baker is doing general duty and will take the course of lectures with the next class of affiliates. After a long term of war service, a "Welcome Home" is extended to Herman Smith and Lorne Weir who are now on the staff. T. F. McCarthy and Stan Brown are doing private duty in the city. Two fever therapy cabinets have been installed on Ward 2 with Norah Roberts in charge.

Anne Matachyk is with the Trans-American Airlines with headquarters in Chicago. Peggy Turner, Louise Thompson, Ethel Sharpe, Mary McGeein, and Mrs. Rex (Janack) King are with the D.V.A. in Kingston. Mrs. E. Alexander has been transferred to London.

Mrs. R. Campbell is serving as president of the alumnae association with Mmes M. White and M. Sherman as vice-presidents, Mrs. W. Scrutton as secretary, and Mrs. N. Ferguson as treasurer.

District 8

Gabrielle DeCelles has been appointed nursing councillor with the Department of National Health and Welfare, Ottawa.

District 10

Fort William:

A recent dinner meeting of District 10, R.N.A.O., was held in conjunction with the annual meeting of the Thunder Bay Nurses' Registry. The reports of the various committees were presented. Madalene Baker, provincial registry adviser, was guest speaker, and she discussed some of the highlights of the Practice Act and answered many questions with regard to this legislation.

Port Arthur:

At a meeting of the Hospital and School of Nursing Section, District 10, there was an

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QUEBEC

MONTREAL:

Royal Victoria Hospital:

Mrs. K. Duncan has been appointed assistant night supervisor in the main building. Miss Barber is in charge of Ward M. Grace Martin and Mrs. R. B. (Fisher) Turnball were recent visitors at the hospital.

Elsie Allder has resigned as director of the teaching department. Appreciation of her work and regret at her departure were expressed at a party held in her honor by the staff nurses, at which time Miss Allder was presented with a combination radio and record player. Miss Rutherford has resigned as nurse in charge of the Ross operating-room. Prior to her departure the staff surgeons gave her a beautiful silver tray, suitably engraved.

Mary Beth Murphy is now assistant head nurse in the operating-room at Victoria Hospital, London, Ont. Janet Morrison is on the staff of the R. W. Large Memorial Hospital, Bella Bella, B.C. Edith McDowell has been appointed Dean of Nursing, University of Western Ontario. Anita Gibson is nursing at a military hospital in the Northwest Territories. Beryl McRae called at Moosonee Nursing Station on James Bay, en route to Fort George to open a nursing station at that outpost.

QUEBEC CITY:

A very successful bridge party was held by the Jeffery Hale's Hospital Alumnae Association, the proceeds going towards the Students Recreational Fund. On the first Sunday in May an inspiring Nurses' Memorial Service was held in the Cathedral of the Holy Trinity, the preacher being the Very Rev. Dean A. H. Crowfoot, who spoke on "Discipline."

Molly Fitzgerald is back on the staff after spending four months at the Toronto General Hospital taking a post-graduate course in operating-room technique. E. Christensen, Miss Grimmer, and J. Skinner are taking a course in tuberculosis nursing at the Weston Hospital, Toronto. H. I. Black is with the D.V.A. Hospital, Quebec City. J. MacTavish, E. Rice, and J. Fraser are doing general duty at J. H. H.

SASKATCHEWAN

MOOSE JAW:

A. Normandin and J. Armstrong, of the Regional Health Centre, were present at the Social Welfare Conference held in Regina.

Judge J. W. McPhee was the very interesting guest speaker at a meeting of Moose Jaw Chapter, District 6, S.R.N.A.

Providence Hospital:

Clementine Laverdière was valedictorian at the graduation exercises when Judge McPhee was the speaker of the evening. Fourteen nurses received their diplomas, awards going to Marion Jameson, Jean Cunningham, Ina Blezard, and Rose Lerner. The banquet, given by the alumnae association in honor of the new class, was enjoyed by all who attended.

Shirley Bays is now on the staff.

REGINA:

Grey Nuns' Hospital:

The Grey Nuns' Hospital Alunmae Association has had a satisfactory year and a summary of past activities is presented: Fifty dollars was presented to the new nurses' residence to purchase engraved coffee spoons. The Chinese Relief Fund, Salvation Army, and Red Cross each received ten dollars from the alumnae. Parcels were sent to overseas nurses. The annual ball was held for the graduates and the exercises took place in May. The alumnae donated a medal for the most efficient bedside nursing. Members attended the Nurses' Memorial Services held in the hospital chapel and at Metropolitan Church on May 4.

The alumnae's executive includes R. Boll as president; Mrs. P. Bard, vice-president; E. Jefferson, secretary-treasurer.

Among the nurses now on the staff are: K. Probert, J. Hodson, E. Jefferson, P. Graham, Y. Nishamura, H. Schmidt, E. O'Bryne, M. Pendergast, L. Robinson, A. Smith, I. Wallwin, R. Dolan, K. Roth, D. Banks, L. Mallow, M. Waddell, R. Rooney, P. Geeson, M. Beacock, M. Findlay, N. Wheeler, O. Brisbain, R. Powell, E. Gross, G. Jack, D. Rodgers, B. MacDougall, N. Kelm; Mmes C. Masterson, A. Hanson, C. Storey.

SASKATOON:

St. Paul's Hospital:

The members of St. Paul's Hospital Alumnae Association were recently addressed by a local photographer on his work. During the evening a picture was taken of those present to be included in the Student Nurses' Year Book.

The "Bonnie Baby" contest, sponsored by the alumnae, was considered to be a "howling" success. There were 150 entrants, all two years of age and under, who were divided into four classes according to age, and a special class for twins. All babies received gifts and the winners were presented with hampers of food and toilet articles, generously donated by local firms. The judges were Mmes A. McPherson, J. S. Thompson, F. G. Salisbury, Mr. Curtis Church, and Mr. J. G. Martin. Tea was served by Mmes D. F. Moore, R. J. Streeter, and Miss I. Mandin.

YORKTON:

The Yorkton General Hospital Alumnae Association held a very successful tea on Hospital Day.

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Assistant Night Supervisor for 100-bed hospital. 6-day week. 1 month vacation with pay after 1 year's service. Apply, stating experience and salary expected, to Supt. of Nurses, Children's Hospital, Winnipeg, Man.

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Sherbrooke Hospital, Sherbrooke, Quebec

Clinical Supervisor for 250-bed hospital. Apply, stating qualifications, experience, and salary expected, to Supt. of Nurses, McKellar Hospital, Fort William, Ont.

Instructor of Nurses (qualified). Duties to commence September 1. Apply to Supt., City Hospital, Sydney, N.S.

Assistant Director of Nursing. Applicant must be qualified to share administrative and teaching duties. Qualified **Dietitian.** For 200-bed hospital. Apply, stating qualifications and experience, to Administrator, General Hospital, Belleville, Ont.

Operating-Room Nurse. Apply in person or write to Lockwood Clinic, 300 Bloor St. E., Toronto 5, Ont.

Public Health Nurses. Recently adjusted salary schedule. Car provided or car allowance. Apply to W. E. Barr, Sec., Northumberland-Durham Health Unit, Cobourg, Ont.

Public Health Nurses with agency specializing in **Tuberculosis.** Health education and case-finding program. Home visiting and clinic duties. No bedside nursing. Experience in tuberculosis preferred but not essential. Nurses without Public Health training desiring experience in this field accepted on temporary basis. Apply to Royal Edward Laurentian Hospital, Dept. of Public Health Nursing, 3674 St. Urbain St., Montreal 18, P.Q.

General Duty Nurses for St. Paul's Hospital, Hearst, Ont. 80-bed hospital. All wards and nursing on one floor. 8-hour day and 6-day week. 1 month's holiday with pay after 1 year's service. 2 weeks' sick leave and hospitalization with pay. Transportation paid to Hearst. Salary: $115 plus full maintenance. Apply to Supt. or to Mrs. M. Loveys, Rm. 413, Wesley Bldgs., 299 Queen St. W., Toronto 2B, Ont.

Nursing Arts Instructor and **Science Instructor.** Psychiatric experience preferable but not essential. Apply, stating qualifications, experience, salary expected, and date of availability, to Supt. of Nurses, Provincial Mental Hospital, Ponoka, Alta.

Classroom Instructress immediately for 125-bed hospital. Apply, stating qualifications, experience, and salary expected, to Supt., General & Marine Hospital, Owen Sound, Ont.

Classroom Instructress for 70-bed hospital. Apply, stating qualifications, experience, and salary expected, to Supt., General Hospital, New Waterford, N.S.

Clinical Supervisor for 150-bed hospital. Student group of 46. For particulars apply to Supt., General Hospital, Medicine Hat, Alta.

Registered Nurses for **General Duty** at Haldimand War Memorial Hospital, Dunnville, Ont. Salary: $120 per month plus full maintenance. 6-day week. Long week-end once per month (3 days). 3 weeks' vacation with pay. Comfortable, homey residence. Pleasant surroundings. Dunnville (pop. 4,500) is one of the beautiful progressive towns in the Niagara Peninsula. Apply to A. M. Casselman, Dunnville, Ont.

Obstetrical Supervisor for Royal Columbian Hospital, New Westminster, B.C. State qualifications, experience, and date of graduation in first letter. Apply to Supt.

Public Health Nurses for Bruce County Health Unit. Minimum salary: $1,600 with provision for yearly increases. Vacations with pay and sick leave allowance. Mileage allowance or car supplied, as desired. Apply to Dr. Wm. Fowler, Director, or Miss Florence Greenaway, Supervising Nurse, Bruce County Health Unit, Walkerton, Ont.

Graduate Nurse, with **Public Health** certificate, for Nursing Service in Secondary Schools, Apply, stating qualifications, experience, age, and other particulars, to Miss Mollie Towers. Sec., Board of Education, Sault Ste. Marie, Ont.

Nurse with **Public Health Training** by September 1 for Child Welfare Association of Montreal. Initial salary: $150. Apply to Executive Director, Child Welfare Association, 1421 Atwater Ave., Montreal 25, P.Q.

Graduate Nurses for **General Duty** in 350-bed **Tuberculosis** Hospital. Salary: $100 per month with full maintenance. 6-day week. Good living conditions. State in first letter age, date of graduation, experience if any, and date available for duty. For further information apply to Miss M. L. Buchanan, Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P.Q.

Registered Nurses for **General Staff** at Tranquille Sanatorium, which is situated on Kamloops Lake, near Kamloops, B.C. Gross salary for 8-hour day, 6-day week: $146.11 per month during 1st year; $156.11 per month during 2nd year; and a $5.00 per month raise in 3rd, 4th, and 5th years of service, minus $27.50 monthly for board, room and laundry. 31 days vacation per annum with pay, plus 11 days statutory holidays. 14 days sick leave each year, accumulative, with pay, plus 6 days incidental illness. Superannuation plan. Up to $50 of fare refunded. Apply to Supt. of Nurses, Tranquille, B.C.

Registered Nurses (4) for **Staff Duty.** 8-hour day; 44-hour week; 5½ day week. Gross salary: $136.50 per month. For further information apply to Miss E. W. Ewart, Supt. of Nurses, Mountain Sanatorium, Hamilton, Ont.

General Staff Nurses. Salary: $140 per month living out, plus laundry. Annual increment. **Operating-Room Nurses.** Post-graduate course essential. Salary: $145 living out, plus laundry. Annual increment. Accumulative sick leave. Hospitalization. Superannuation 31 days vacation. Statutory holidays. 8-hour day and 6-day week. State in first letter date of graduation, experience, references, etc., when services would be available, and whether eligible for registration in British Columbia. Please note that investigation should be made with regard to registration in B.C. Apply to Director of Nursing, General Hospital, Vancouver, B.C.

Floor Duty Nurse. 6-day week. Salary: $100 per month; full maintenance and free hospitalization. **Operating-Room Nurse.** Apply, with references, to **Supt., Barrie Memorial Hospital, Ormstown, P.Q.**

General Duty Nurses for 20-bed fully modern hospital. Salary: $120 per month and full maintenance. 6-day week. Apply to Supt. of Nurses, Municipal Hospital, Brooks, Alta.

Superintendent for active 20-bed hospital. Good salary and working conditions. Apply stating qualifications, to Chairman, Hospital Board, Palmerston, Ont.

Nursing Arts Instructor. Dietitian. Assistant to **Night Supervisor. General Duty Nurses.** For 250-bed General Hospital. Apply, stating qualifications, experience, and salary expected, to Supt. of Nurses, General Hospital, Brandon, Man.

Instructor of Nurses. Salary: $140 per month and full maintenance. **Dietitian.** Salary: $130 per month and full maintenance. Apply to Supt., General Hospital, Kenora, Ont.

Public Health Nurses for generalized service with Peel County Health Unit. Salary: $1,800-$2,100 according to experience. Car supplied or car allowance $500-$600 per year. Unit will assist in purchase of car. Apply to Dr. D. G. H. MacDonald, Director, Court House, Brampton, Ont.

Graduate, General Duty Nurses (2). Salary: $110 per month with full maintenance. 8-hour day and 6-day week. Apply to Secretary-Treasurer, Little Bow Municipal Hospital No. 25, Carmangay, Alta.

Licensed Nurses for **General Duty** in 51-bed hospital. **Nurse** with **Operating-Room** experience. Basic salary: $114.50 per month plus full maintenance; $5.00 increase in salary after 6 months. 3 weeks' vacation each year with pay. Apply to Miss M. N. DeVere, Supt. of Nurses, Saguenay General Hospital, Arvida, P.Q.

Registered Nurses for **General Duty** at Royal Jubilee Hospital, Victoria, B.C. State in first letter year of graduation, experience, references, etc., and when available. Starting salary: $140 per month, living out. Yearly salary increases up to $160 in 4 years. Special post-graduate training—Starting salary: $150 with increases to $170 in 4 years. Laundry allowed. A few rooms available in residence. Sick leave allowance, cumulative 1½ days per month. Superannuation. 4 weeks' vacation per year with pay. Investigation should be made with regard to registration in British Columbia. Apply to Director of Nursing.

Instructor for small Training School. Private room with full maintenance. Apply, with references and stating salary expected, to Plummer Memorial Public Hospital, Sault Ste. Marie, Ont.

Registered Nurses for **General Staff Nursing** in **Medical, Surgical,** and **Obstetrical** Depts. **Operating-Room Nurse** and **Assistant Night Supervisor.** For 100-bed General Hospital in Western Ontario. 8-hour day and 48-hour week. Apply, stating qualifications and salary expected, to Supt. of Nurses, General Hospital, Woodstock, Ont.

Graduate Nurses for **Operating-Room, Charge Duty,** and **General Duty. X-Ray Technician.** Apply giving experience, to Supt., Blanchard-Fraser Memorial Hospital, Kentville, N.S.

General Staff Nurses. Initial salary: $140 per month and laundry. First increment is granted after 6 months. 8-hour day and 6-day week. 3 weeks' annual vacation. Apply to Supt. of Nurses, General Hospital, Toronto, Ont.

Registered Nurses (3) for **General Duty** in 30-bed hospital located in southern interior of B.C. near U.S. border. 2 active surgeons on staff. Gross salary: $135 per month. 4 weeks' vacation with pay. Generous recreational facilities. Popular summer resort nearby. Apply to Sec., Community Hospital, Grand Forks, B.C.

Graduate Nurses for **General Duty.** $145 per month. 8-hour day and 6-day week. For further information apply to Supt., St. Peter's Hospital, Melville, Sask.

Getting Results!

"I thought you might like to know the response to an advertisement for an operating-room nurse which appeared in *The Canadian Nurse* in January and February of this year.

"Five replies were received and a Toronto nurse was selected and planned to come on July 15, but serious illness of her mother made it necessary for her to cancel the appointment. A second applicant was selected from Montreal and she will report on duty August 11.

"We feel that our problem has been satisfactorily solved for us through this advertisement, as all the applicants were suitably qualified to meet the requirements of the position offered.

"Thank you for your help in this matter."

Nursing Sisters' Association

The *Toronto Unit* joined with other nurses in the Toronto area in the annual Nurses' Memorial Service, held on May 4, and arranged by District 5, R.N.A.O. The Protestant service, held at Metropolitan United Church, was under the direction of the Very Rev. Peter Bryce, D.D., LL.D. St. Michael's Cathedral was the scene of the Roman Catholic service and was conducted by the Rev. Father Hendricks and the Rev. J. W. Dore. About fifteen hundred nurses, including large groups of students, attended the services.

Several members of the unit attended the I.C.N. Congress held in Atlantic City, including Agnes Neill, Ethel Greenwood, Edna Moore, Doris Kent, Maude Wilkinson, Gladys Sharpe, Helen Heffernan, Ethel Cryderman, Mary Sunley, Alice Ross, Margaret Kennedy, Dorothy Riddell. Misses Wilkinson and Sunley spent a week in New York following the Congress, sitting in at several meetings of the United Nations.